Health Care Cost Trends Hearings

6-30-11 AM

Seena Perumal Carrington

Thank you all for joining us and I welcome you to the fourth and final day of the division's public hearings on health care cost trends. I don't know about you, but I'm breathing a sigh of relief that it's almost over -- one more day to go. So I'm Seena Perumal Carrington, Acting Commissioner of the Division of Health care Finance and Policy and chair of these hearings. I'm joined today by Assistant Attorney General Lois Johnson. As I was thinking about my remarks this morning, I decided that I wanted to begin by explaining why we chose this structure, this format, and these topics. When the division held its health care cost trend hearings in 2010, it was our first year. The hearings were meant to be table setting and we were thrilled just to have every participant note a sense of urgency in containing costs. Well, that urgency obviously hasn't diminished any and we wouldn't have been satisfied to simply repeat the same format as last year, nor could we ignore the fact that the governor has boldly proposed comprehensive changes to the health care delivery system. While his bill quickly gets summarized as payment reform or delivery system reform, it

obviously goes much further and it addresses many of the challenges confronting us from variation in provider prices to payment methodology to health resource planning to the need for integration. And so we decided to use these hearings to examine each of those topics. We didn't ask you to respond to the governor's bill because we weren't interested in debating the merits of the language or using panel discussions to wordsmith. Somehow, I trust that many of you are already engaging in those efforts privately. Rather, we wanted to know if you agree that an issue is a challenge -- whether you agree, actions need to be taking, and whether you have a suggestion for a solution. So now, with three days behind us, I wanted to reflect on some of what we heard. My team and I will be replaying this video many times over the coming weeks to develop a final report with recommendations to the legislature, but I wanted to share my preliminary thoughts. I do this now instead of later because if you're anything like me, by 5 PM, the last thing you want to do is hear long closing remarks. So some panels worked out well and others less so. Those who know me well know that I can be demanding and that I have very high expectations, but if we are to ever make progress in containing costs, we can't sit around and pat ourselves on the back. We have to be honest about what was said and if we progressed at all. So on Monday, the analysis from the Division of Health Care Finance and Policy and

the Office of the Attorney General highlighted the continuing rise in health care costs and some of the factors that may underlie its growth. Both of our offices are committed to continue to monitor the health care delivery system. And as we move forward with cost containment strategies, we need to know where we began to know if we succeeded. We need to identify potential issues and publicly address these challenges before they become permanent roadblocks and hopefully we at the Division, we have demonstrated time and time again that we're not interested in playing favorites or towing a certain line. Rather, we want data, we want transparency, and we want to be objective. I'm proud of the role that the agency plays. I know we have the necessary expertise and experience and I look to the legislature to expand and enhance the Division's role in its final legislation. On Monday, we also heard from key state officials, notably Governor Patrick, Chairman Moore, Chairman Walsh, and Chairman Sanchez. All four noted the urgency of taking action now and conveyed their commitment to developing strategies that would lead to lasting meaningful change. So Monday overall, a little data heavy, a little speech heavy, but overall strong. So let's turn to Tuesday. We shifted our focus to the wide variation in prices paid to providers for the same services. In the first panel discussion, there was near universal agreement that the extent of price variation reflected

on healthy imbalance in the health care marketplace that merits immediate government intervention. While getting four of those five individuals to agree to such action was significant enough. We unfortunately weren't able to determine what exactly that intervention should be. I hope we can continue that conversation in the recently convened Special Commission on Provider Price Reform. In the second panel, there was universal agreement that transparency alone wasn't sufficient to impact utilization patterns. Rather, panelists generally wanted to continue promoting insurance product options that direct care to efficient, low-cost providers such as [Sellet? 4:18] and tiered network products. However, besides paying lip service to concepts such as consumer engagement and education, we never talked about who bears responsibility for those functions or where the necessary investments will come from. Interestingly, this panel, mainly composed of purchasers and consumer advocates, was more divided on the role of government and also whether government intervention was needed to reduce price variation, even in the face of escalating health care costs, that there seems to just be so many different perspectives on sort of market innovation and progress versus government intervention and regulation. So on Tuesday overall, we made fairly significant progress, but we didn't answer the specifics. But perhaps, I'm just being too hard on us, because that might

be too much to ask for in an hour and a half. So on Wednesday, we turned to payment methodologies and all the panelists in the morning agreed that we need to realign to promote an integrated delivery system that rewards quality, cost-effectiveness, patient center care provided in the most appropriate settings. In fact, the group unanimously agreed that in five to seven years, global payments should be the predominant method of payment in the Commonwealth. They also noted a number of different challenges confronting us, as we transition to global payments, such as the management of performance risk and the need for oversight, but couldn't once again agree on the role of government and market and addressing or removing those issues. Interestingly, this panel overwhelmingly touted the benefits of transparency, not to change consumer behavior, but rather to increase provider and payer accountability. Additionally, they agreed that payment reform was necessary, but not sufficient, and so similar to the Governor and the Attorney General's office, the panelists echoed the call for more comprehensive changes. In the afternoon, we discussed health resource planning. Panelists agreed that we should better leverage existing services to meet current and future demands. Panelists noted the investments that are going to be needed in infrastructure, IT, workforce public health, et cetera, but we failed to discuss how those investments can be cost neutral. We

also didn’t go into the details on how certain groups adjust to a new integrated delivery system, or as traditional roles may become outdated and new needs will become apparent. We also avoided the challenging question of whether excess capacity exists in the system now and if it does, what we do about it. But at least we agree health resource planning is needed and I guess that’s progress. So on Wednesday, we started strong, but the temple faded and we ended without clear direction. So today, we’re going to turn to yet another challenge in the health care delivery system and that’s the need for integration in care coordination. We’re going to start with the presentation of analytical findings from the Division of Health Care Finance and Policy. We’re specifically going to look at new 2009 analysis on preventable hospitalizations or avoidable ED visits and potentially preventable readmissions. We’re then going to hear from the Office of the Attorney General on the challenges here for our nation as well. Next, we will hear expert witness testimony from Doctor Jody Gittell, Professor of Management at Brandeis University’s Heller School for Social Policy and Management. We’re going to conclude this session with a response panel of various stakeholders. I urge the panelists to be honest and direct, because those types of discussions are most fruitful. And after a short 30 minute lunch break, we’re going to reconvene promptly at 1:15. But this time, instead of

discussing challenges, we're going to turn the conversation to solutions. We're going to hear expert witness testimony from Doctor Paul Ginsburg, President of the Center for Studying Health System Change and he's going to discuss the potential roles for government and market and reducing costs. That seems to be the theme that we never could agree on, and so we're actually going to address it, and we're going to hear the thoughts of a response panel. Similar to the other days, there are index cards available in your folder. Please write any questions that you may have for panelists and give them to members of the team who are going to be walking around. At the end of each panel, the moderator will ask some of these submitted questions. Additionally, today there's an opportunity for any of you who's interested to provide brief comments. There's a signup sheet out front at the registration table and if you have thoughts on some of the areas where I noted we fell short, please share it either today or in written comments to the agency. Your insights are going to help us develop a finer report with recommendations to provide to the legislature. And so at this time, I'd like to invite Stacey Eccleston, Assistant Commissioner for Health Research and Policy, to speak. Thank you, Stacey.

Stacey Eccleston

Thank you. So we've heard throughout these hearings and we'll likely hear more today about the importance of care coordination in not only improving health outcomes, but also potentially saving costs in the system. So today, what we want to do, what this presentation will do, we'll describe factors that are associated with three indicators that might suggest the need for better care coordination. The first is potentially preventable hospitalizations, then potentially preventable readmissions, and then avoidable ED visits. We'll take a look and assess the potential savings that are associated with each of these and then we'll also describe some results of some recent community health center efforts that were aimed at reducing avoidable ED visits and see what those results were. So why do we want to take a look at these things? Well, first is, avoidable ED visits and preventable hospitalizations can tell us about potential barriers to accessing appropriate care in the community and might point to the need for better coordination. Differences in ED use and preventable hospitalizations that we see across, you know, different geographic areas or within different ethnic or racial ethnicities, or other socioeconomic factors, can really tell us about the needs for better care coordination for certain segments of the population. Avoidable

EDUs and preventable hospitalizations certainly lead to excess costs and therefore present opportunities for savings in the system. And greater emphasis on primary care patient center models might help to reduce avoidable ED visits and preventable hospitalizations and then help mitigate that cost over time. So what are these? So just a quick definition. Preventable hospitalizations, and I'll refer to them as PHs throughout this report, are the inpatient treatment of conditions for which good, ongoing outpatient care could potentially prevent the need for that inpatient episode or for which early interventions could prevent complications that necessitate inpatient stays. So a mix of both acute and chronic things, like hospitalizations for asthma, diabetes, urinary tract infections and pneumonia. The methods that we use simply are the ARC prevention quality indicators, and it's basically a downloadable program from ARC, and we apply it to the division's hospital case mixed data, so this is data that comes directly from the hospitals on their inpatient stays. The potentially preventable readmissions, or PPRs as we'll refer to them throughout, are subsequent hospitalization after initial hospitalization, and in this case, within 30 days after that initial hospitalization, where that subsequent hospitalization is determined to be clinically related to the first hospitalization. In this method here, we use the three M PPR methodology, again applied to that same case

mixed data that we get from the hospitals. The avoidable ED visits are visits that are determined to be either non-urgent, so care is not needed within 12 hours, there are urgent but maybe primary-care treatable, so care was needed within 12 hours but the care could've been delivered in a physician's office, or they're urgent, so again care needed within 12 hours, but the condition could've been prevented had a good primary care access happened, where the condition itself wouldn't have been exacerbated, had that primary care been used. So here for ED visits, we're using the billings algorithm. Also available as a download from ARC, but modified by the division to account for what are new I-CD9s over time, since that was developed. So we wouldn't see distortions for example in the trends caused by having new I-CD9s that were falling out of the algorithm. As I mentioned, all three of these measure were based on the hospital discharge data set, and it's for fiscal year 2009. So the costs that are associated with each of these three events totaled nearly $2 billion for fiscal year 2009 alone and each makes up roughly about one-third of those costs, with the inpatient events accounting for a bit more because of the high costs that are associated with inpatient stays. So preventable hospitalizations and preventable readmissions accounted for 36 and 35% of total costs associated with these and the ED visits accounted for about 29%. Now we expect that a good part of these

costs associated with these things could be realized in system savings, but probably not all of the costs. For the ED visits for example, some portion are what we consider to be things that could've been treated in a primary care office instead of the ED, and so the elimination or, you know, the avoidance of the ED, would be somewhat offset by the costs that would be incurred at that physician's office, though certainly not nearly as high as what we see in the ED. And similarly, a rate of zero percent for preventable hospitalizations or readmissions probably isn't realistic, but certainly a good chunk of that $2 billion could be realized in systems savings. Let's take a quick look at each one of these slices in a little bit more detail, starting with the preventable hospitalizations. In here, we're looking at the adult population, so over 18, and of the nearly 700,000 adult inpatient admissions, about 12% were considered to be potentially preventable -- that's the blue section here, accounting for $719 million in estimated costs out of the total $8 billion in inpatient hospital costs. So what are these conditions for which there was a hospitalization that might've been avoided? They include, as I said, both acute and chronic conditions, but mostly chronic here -- things like congestive heart failure, which accounts for about 24% of the preventable hospitalizations, while admissions for bacterial pneumonia account for about 19%. Other conditions that are associated with

preventable hospitalizations include COPD, urinary tract infections, asthma, diabetes related things, and hypertension related conditions. The good news though is that Massachusetts does fairly well and has lower rates of preventable hospitalizations when we compare it to the rest of the nation for at least 9 of these 12 conditions, although we see higher rates for COPD, asthma, and UTI, so the risk-adjusted rates per 100,000 residents for short-term diabetes was 44 compared to 60 per 100,000 US residents, and this is for fiscal year 2009 and lower for each of the diabetes' chronic conditions. And of the total admissions for each of the pair types, the rate of preventable hospitalization as a percent of total admissions was highest for the Medicare population. Given the type of conditions that we're talking about, this is probably not too surprising. Seven percent of all hospitalizations for private pairs were deemed potentially preventable compared to eight percent for Comm care and 10% for Medicaid and then 17% for Medicare. So different payers are prevented by preventable hospitalizations disproportionately, making the need to focus in this area, perhaps more urgent for the Medicare population. A study that we did last year shows that there is geographic differences across the state in these, as well as substantial differences across the different racial and ethnic categories as well. So what about the potentially preventable readmissions?

For potentially preventable readmissions, and remember these are readmits to a hospital within 30 days of an initial hospitalization for something that's directly related to that initial hospitalization. The statewide rate was about 8.9%, so 8.9% of inpatient stays resulted in some kind of readmission within 30 days. Here, we talk about readmission chains, because there might be a series of readmissions that we're counting and tying to that initial admission. The rate was higher for medical conditions, 11%, compared to surgical conditions, which was 8%. The range across individual hospitals in this category was from a low of 5.6%, meaning the hospital with the initial admission, to a higher rate of nearly 14%, but most hospitals fell between 8-10 for this measure. Those were really outliers at the extremes. The estimated costs associated with these was just over $7 million in fiscal year 2009. And unlike the preventable hospitalizations that we just looked at, Massachusetts doesn't do as well as the rest of the nation on this particular measure in preventing readmissions. We have a higher rate compared to the national rates for heart attack, heart failure, and pneumonia -- some very common admission types. Several service lines, and here we're talking about the categories of the inpatient admissions, had PPR rates that were above the statewide average rate. Nearly 17% of initial admissions for myocardial infarction resulted in at least one

readmission. Similarly, higher rates for cardiovascular surgery, nephrology, hematology, and psychiatry. Together, the admissions for just these five service lines accounted for about $117 million in estimated hospital costs. Unlike what we found for preventable hospitalizations and avoidable ED visits as we'll see a minute, there's very little variation in PPR rates observed by either payer type or by geographical region, or hospital status, such as Dish status or our teaching hospitals. So the PPR rates were similar across the different providers, somewhat lower for the Medicare and Medicaid, compared to commercial fares. There was a little difference in PPR rates across EMS regions, ranging from about 8.4% to 10%. Rates were lowest for Boston metro area, and highest for western Mass. The average PPR rate for teaching hospitals was just marginally lower that what we see for community hospitals -- about 8.6% compared to 9%. And the average rate for disproportionate chair hospitals was marginally lower than the average PPR rate for non-Dish hospitals. And now for the avoidable or preventable ED visits, about one-half of outpatient ED visits were considered preventable or avoidable in fiscal year 2009. Outpatient ED visits are those that don't result in an inpatient admission and those make up about 80% of all ED visits, so even if you consider all of the inpatient visits to be emerge in ED visits, we're still talking about a rate of about 40% are preventable or

avoidable. The truly emergent visits make up about 39%, so these are injuries and traumatic injuries and diseases. Mental health and substance abuse, which is a separate category here, so not included in either the emergent or avoidable ED visits, those made up about six percent of visits and about eight percent of ED visits were not able to be classified and this rate of eight percent has been relatively constant over time. The definition of what is preventable, avoidable, is fairly broad and it's more than just something that's not a time sensitive emergency. There's three categories here. Non-emergency makes up about 22 percentage points of the 48%. These are things where the care was not required within 12 hours, so a sore throat for a example is a major service in this category. Emergent but primary-care treatable category makes up about 20 points of the 48%. These are things that didn't require or rather they did require treatment within 12 hours, but they could've been treated in a primary care setting, assuming that, you know, a physician's office for example, assuming that access could be obtained. A significant category here would be infant fevers. You know, they need to be seen, but preferably in the pediatrician's office. And the last category, emergent but avoidable condition, makes up six points of the 48%. These are things that require treatment within the 12 hours, but the urgency of the condition could've been avoided with better

primary care, and these are things such as an asthma flare up, so all of these speak to the need for better care coordination. Some good news here that we can cite is that the rate of ED visits generally, so these are all ED visits, has been declining, particularly recently from 2009 to 2010. Here, we're looking at the overall ED visit rate, not just the preventable avoidable category, and since we're looking at the overall rate, we can go out to 2010 here. In 2010, the rate was basically flat, even after adjusting for what is a slight population decrease in this time period. This compares to an annual increase of about two percent over the period from 2006-2008. So even with the influx of insured lives in this system, we seem to be adjusting in the long run. And it's the preventable or avoidable visits actually that were on a decline between 2008-2009 at least. Here, we're showing the trend in the volume of each of the categories of ED visits, including the mental health category. The trend is shown indexed to 2006, so 2006 here is equal to 100. So total ED visits, represented here by the purple line, was about six percent higher in volume in 2009 than it was compared to 2006. The emergent visits shown here in the green were relatively flat over the entire period. The increase in the overall ED visits rat her was driven by an increase in the preventable avoidable visits prior to the 2008 period, but not after, and by the mental health visits particularly after 2007.

That’s the line in the dark blue here. Overall, about five percent of patients have five or more ED visits in a 12-month period, accounting for more than 21% of the total outpatient ED visits in a given year. So we referred to those that have more than five visits in a 12 month period as frequent users. About six percent of patients that had an alcohol-related ED visit were considered frequent users. The frequent alcohol-related ED visit users had an average of 11 visits in the 12-month period and accounted for about one-third of the ED visits for alcohol-related conditions in fiscal year 2009. What about geographic areas and differences there, or in this case, designated, medically, underserved populations. Here we see that all but one of these underserved population areas had a higher rate of preventable avoidable visits per 1,000 residents, compared to the state average of about 182 per 1,000. A medically underserved population is defined by the Health Resources Services Administration, and it’s designated as areas with economic barriers or cultural -- and the economic barriers are basically low income, or cultural or linguistic access barriers to primary care medical services. So these areas also have high public payer populations. In many cases, these higher rates here also coincide with higher rates for the emergent visits as well, but in every case, the proportion of all of the ED visits that are preventable or avoidable was higher and here, our

information was only available for 2008 rather than 2009. You'll notice despite being designated, a medically underserved population area, Lowell had a lower rate of preventable avoidable ED visits compared to the rest of the state. Lowell also has a large and a growing Asian population compared to the state average, as well as all the other low-income areas that are depicted in this slide. 17% compared to about 4% across the state -- the Asian population, when we look at our ethnicity data, is also associated with lower rates of preventable avoidable, as well as general ED used generally. We also see different rates by age. Younger adults having higher percentages and we see different rates by race and ethnicity as well -- higher rates for Black and Hispanic populations. And again, when we look at payer types for the avoid able ED visits, we see that CommCare, Medicaid, and the uninsured had the highest proportion of their ED visits that were considered potentially avoidable and preventable, although the uninsured make up an extremely small percentage of the population here and therefore an extremely small percentage of the ED visits. The whole other category here are things like auto insurance, for example. As you can imagine, those are more injury-related things, so a very low rate of avoidable ED visits. The Medicaid population had higher rates of avoidable ED Visits and also had relatively higher proportion of frequent ED users compared to the other

payers here. It’s appropriate that diversion efforts target this particular population. The CMS ED diversion program was initiated in 2008. The state received about $4.5 million grant from CMS for funding specifically to reduce use of the EDs by medicated patients for non-emergency conditions. Improve access to urgent care at local community health centers. Improve access to ongoing primary care for Mass Health beneficiaries. Education from Mass Health beneficiaries about the appropriate uses of EDs and their community health centers, to determine cost savings to the Massachusetts health system as a result of diverting ED visits to community health centers or to primary care and to improve collaborative efforts between community health centers and their community hospitals. The program was administered by Neighborhood Health Plan, a carrier who has a significant membership base in Medicaid and a significant amount of patients at their various community health centers throughout the state. 17 health centers participated in the program and used various award amounts to fund initiatives in one of three areas -- one or more of three areas, expanded hours of operation, so opening evening hours and/or weekend hours, expand the capacity for urgent care by adding additional hours and staff during their existing hours, or even expanding physical space and creating medical home linkages that were focused on strengthening the medical home concept through nurse triage

systems and care management and reaching out to patients to set them up with a primary care physician. So these are the centers that were involved in the grant and the interventions that each of them implemented. Most expanded on urgent care and that's the middle bar here, the green bar. A few did all three interventions, so expanding the hours in the orange, expanding the urgent care and primary care access in the green, and creating medical home linkages here in the blue. So between the baseline period, so the period of time before the intervention was implemented, and the intervention period itself, 12 out of the 15 community health centers, or about 80%, showed a reduction in the proportion of total ED visits that were considered non-emergent. Overall, the average change in non-emergent ED visits for all participating CHCs was just under a two percent drop. The biggest drop here was 8.8 percentage point drop in the proportion of ED visits considered to be non-emergent. That center did two of the interventions. It expanded hours and expanded urgent care and primary care access. The next highest drop here, 5.9 percentage points, did the same two interventions, but our next highest drop in the non-emergent ED visits, the 5.4 percentage points, only did the third intervention, the medical home linkages. So we can't point to one or the other intervention as being the key to better outcomes, but it may be something more subtle in the

implementation process, but overall, a fairly good success rate. So this looks at the change in non-emergent or you know, not time sensitive and treatable in a physician's office conditions that seek ED care. We can also look at two other categories that they looked at, ambulatory sensitive, so amenable to primary care, to you know, alleviate an exacerbation of a condition, and the low acuity ED utilization, those that are just determined not serious enough for treatment in that setting. Overall, the majority of the participating CHCs, about 53% reported a reduction in both of these types of ED visits, between the baseline period and the intervention period. Over 73%, about 11 out of the 15, and 67%, 10 out of the 15 CHCs reported reductions in either one of the two. Only community health centers had an increase in both metrics over this time period. One other interesting finding here is that there didn't appear to be an apparent impact on the frequent users -- remember, those users who had five or more visits in a 12 month period. So these changes didn't seem to be able to impact the more habitual users. So diverting all or some of the total 22,000 patient visits reported by the participating CHCs, resulted in savings of anywhere between $1 million and $4.2 million for the Mass health care system, depending on the assumptions that you apply. So we assume the average payment of $316 for a Medicaid ED visit versus the average cost of a community health center

visit of $126. The most significant savings are achieved if we assume that all of the avoidable ED visits instead went to the community health centers, so 4.2 million here. We see 2.1 million in savings if we assume half of those ED visits were diverted to the community health center, and if one-quarter of the visits were diverted, then about $1 million in savings. Now this is just the savings that would be achieved from this one payer at the 17 community health centers that they service. As I mentioned, we have results from last year's reports on our website for the preventable hospitalizations and the avoidable ED visits, so you can see more detail on those and we'll be updating those soon with additional information including 2010 and we'll also be publishing more detail on the CMS diverging project as well, so please visit the website if you'd like to get more information on that. Thank you.

Seena Perumal Carrington

Thank you, Stacey. Now the Assistant Attorney General Lois Johnson will present.

Lois Johnson

Good morning. My name is Lois Johnson. I'm Assistant Attorney General in Attorney General Martha Coakley's Health Care Division. I'm here this morning to address the topic of challenges in care coordination. With me today is Doctor John Freedman, who provided expert assistance in our examination and report. And in our examination, we relied on information from many providers and health plans. I just want to take this opportunity as my colleagues have this week to thank you for your assistance throughout this process. This morning, we're going to discuss a key finding of the AGO report, which is that a variety of provider organizations of different sizes and structures designed around primary care can deliver coordinated care with the appropriate data and resources. So first, what is care coordination? As we all know, we do not just receive one type of health care service from one type of health care provider. In any given year, we may see a primary care provider, a PCP, we may see one or more specialists, we may go to hospitals for outpatient services, we may have a delivery, a surgery, we may have tests and labs along the way, at some point we may need home care or skilled nursing treatment. Many believe that a goal of delivery system reform and indeed payment reform is how to improve this care delivery so that patient care is

better coordinated or managed across these different care settings. For purposes of our report, we used the term coordinated patient care, or coordinated care, to mean quality care that is primary care based, managed over time and across settings, in a way that's patient-centered, reflecting the best needs of the patient and the best interest of the patient. So the goal of care coordination is to improve both the quality and efficiency of care. For example, it would result in shared information between a primary care provider and a specialist, improve transitions of care from inpatient to outpatient settings to avoid the hospital admissions and readmissions that Stacey described. As Stacey indicated, and her data shows, there is room for improvement in Massachusetts and opportunity for improvement as well. As policymakers consider ways to redesign care, many have suggested accountable care organizations, or ACOs, as a new model of delivering coordinated care. As Harold Miller said yesterday, everybody's talking about ACOs and everybody's trying to define them. Generally though, ACOs are provider organizations that are responsible for the quality and cost of care, cost of continuum of care for a given population of patients. Many think about what should ACOs look like, how big should they be, how should they be organized, and so on. And some envision different levels of ACOs, whereby certain organizational structures, like hospital-based systems

or large integrated systems, are better equipped than others to be held accountable for patient care. To look at some of these questions, the AGO conducted a study of 16 provider organizations in Massachusetts. We looked at these groups to consider how are they providing coordinated care? What makes these providers successful? How can we measure whether care is well-coordinated at both the provider level and the system-wise level? The goal of our examination wasn't to show the best way to coordinate care. Physician experts and hospital policy experts in the audience can do that. Our goal was not to showcase different providers over others or even to define an ACO. Instead, we sought to examine how a range of provider groups are doing this work on the ground to look at available data, to hear from the providers themselves about their experiences and draw some lessons for policymakers considering system redesign. So our key finding is that health care provider organizations designed around primary care can coordinate care effectively one, through a variety of organizational models, two, provided they have appropriate data and resources, and three, while global payments may encourage care coordination, they pose significant challenges. This week, my colleagues discussed some of the particular challenges facing providers at risk for global payment structures, so I'm going to focus more on points one and two -- organizational structure and data and

resources, but it is important to point out that providers face challenges in care coordination regardless of their payment methods. So whether or not they're in fee for service or for global payment structures, they still face the same care coordination challenges. So we're fortunate in Massachusetts, as many have said, to have high quality physician groups across the Commonwealth. For our analysis, we selected 16 of these provider organizations from different geographic areas. These organizations represent a range of different organizational models that we see across the state. For our analysis, we looked at four key aspects of these organizational models -- size, scope of services, clinical structure, and corporate structure. And in our group of 16 providers, the size varied considerably, from the smallest group of 23 physicians to a large group of over 5400 physicians, and many sizes in-between. We also looked -- to compare size, we looked at the comparative size based on the number of member months each provider group had with particular insurers. So in one insurer network for example, the largest of our group had 30 times the number of member months as the smallest group, so a wide range of sizes. In terms of scope of services, we looked at the type of services offered in-house within each provider organization, whether it was PCP only, PCP plus specialists, added pharmacy or ancillary services -- we looked at organizations that included not only physician

services, but acute and sub-acute facilities and home care, et cetera. For clinical structure, we learned that clinical relationships of provider groups are complex, that they vary over time, and can even vary by contract with different payers. For purposes of looking at clinical structure here, we considered generally whether the organization was physician-based or primarily hospital-based. Physician-based groups included a PCP only practice, the multi-specialty practices, independent practice associates or IPAs. Hospital-based groups included physician hospital organizations or PHOs, large networks that were linked to hospitals either through contracting or ownership. In corporate structure, we distinguished between groups who were integrated health systems, those who had corporate ownership over physician networks and multiple hospitals and other facilities and a few of those examples were in our 16 provider cohort. So we found that no one size or shape fits all in terms of which type of provider organization is better positioned to deliver coordinated care -- no preferred ACO model. We found each of the 16 groups performed well on measures of physician quality. Each scored above the national average of the HEDIS measure set, the NCQA measure set that Doctor John Freedman will describe and their organizational structure was not a factor in the differences in overall quality or in how well those groups provided coordinated care. We found

that providers across the spectrum of size in organizational model use a variety of systems to manage care, with infrastructure tailored to the unique nature of their organization. Coordinated care, we found, can be delivered in both physician-based or hospital-based practices, incorporate the integrated groups in small and large groups. Consider a PHO for example in a multi-specialty practice. While the PHO physicians have a direct relationship with the hospital with whom they contract, the multi-specialty practice refers patients to a number of preferred hospitals, with whom it maintains clinical integration arrangements. IPAs which comprise a membership of many independent and solo practices, may be independent from, but closely assign with a particular hospital. IPAs use physician participation agreements to implement standards and systems across their organization, like EMR and shared data warehouses across those solo practitioners and small practices to integrate care. So while one might expect that larger groups are those affiliated with hospitals or owned by health systems with more resources would have more systems in place to coordinate care, we found, like many other researchers, that corporate integration is not the same as clinical integration. While a large system may indeed have more resources, they may not have been dedicating those resources explicitly to care coordination across the enterprise. We found

for example that some integrated health systems are only recently making those investments. For example, a large integrated system recently made an investment of $100 million in IT to deploy that across the enterprise, while some smaller IPAs have had unified EMR for some time. And while there may advantages and disadvantages to different models, some of which are described in our report, we found that a variety of provider organizations can and are implementing systems to provide coordinated care. So is one model at doing this than others? And based on the data that we reviewed, the answer is no. To conduct our analysis, we looked at measures of care coordination and we found that there's no single nationally recognized measure of care coordination. As Doctor Freedman will describe, we identified a subset of physician HEDIS measures as a good indicator of care coordination. These measures assess performance on particular conditions for which care must be provided across time and across settings. For example, comprehensive diabetes care was one of the measures we looked at. Based on our review, we saw no evidence that larger groups performed consistently better or worse than other groups on these care coordination measures. Likewise, no evidence that corporately integrated health systems performed better or worse than other groups and no evidence that hospital-based groups performed better or worse than physician groups on a consistent

basis. A challenge common to all of these provider groups studied is the difficulty of managing care of patients who choose to receive some or part of that care outside of that provider's own organization, described by some of these hearings as out migration or leakage. Our analysis of referral patterns shows that all provider groups can experience leakage of a significant proportion of their care. For example, analysis of health plan data showed out migration of 55 to 65% in revenue turns in adult inpatient admissions for two PHOs that we looked at. This raises the issue of insurance product design and the importance of primary care to manage referrals and to maximize these care management systems and I'll turn to that next. So while our analysis showed that no one model is better than others, providers of all types told us that three tools were essential to p providing coordinated care. One was primary care providers. Two, care management infrastructure. And three, data. The first element is primary care providers. You've heard throughout these hearings that primary care providers have a central role to play in providing care coordination. Several providers make this point eloquently in their pre-file testimony, which I encourage you to read. Yet we found that popular insurance products in the market did not necessarily support this model. In an HMO product, members select a PCP who manages patient referrals to different providers, and tracks

important information about their care. With that referral authority, that PCP can refer patients to lower cost, high quality providers, and take advantage of important clinical affiliations and that care management infrastructure they worked so hard to build. With information about your hospitalization and test results for example, your PCP can monitor your recovery and make sure you keep healthy after you discharge. In contrast, members in PPO plans are not required to select a PCP who has that same authority and information to manage your care appropriately. If you're in a PPO product, your doctor may not even know you were hospitalized. As a result, these PPO products present significant challenges in improving care coordination. And why is this a concern? Well PPO membership is growing. Currently 42% of the membership in our largest three health plans are in PPO products and this is growing. Over the past five years, 400,000 lives have moved from HMO to PPO products. So even as we're trying to encourage the system to more coordinated care and find that providers are investing in care coordination infrastructure, the market is moving in the opposite direction. The second key piece is care management infrastructure. Care coordination is not an automatic byproduct of global payments. Providers told us that effective care coordination requires money, time, and effort to build care management infrastructure, whether they're paid on a fee per

service basis or globally paid basis. The providers we studied, as I said, use different approaches and the amount and type of their infrastructure differed subject to their available resources. Health plan support care management infrastructure in their fee for service or global payments. Providers did tell us that infrastructure is needed to support three main and interrelated functions -- patient care management, whether it's clinical staff and medical management program efforts, to physician engagement and quality improvement. Groups need systems to measure and track physician quality to develop care practice protocols and patient care pathways, to communicate with physicians and help them improve. They need data. Whether it's electronic, medical, or health records, data warehouses to analyze claims, to monitor utilization of services and analytics to support all these. The costs of care management infrastructure vary as these approaches vary, and with the scale of enterprise we're talking about, but we found that significant resources are needed. Ways of accounting for these costs do vary across provider organizations, which did limit our ability to do apples to apples comparisons of these costs. For example, some providers include EMR in their care coordination totals. Others do not. Several providers gave us estimates of approximately 10 to 26 dollars per member per month being spent on care coordination. Just to put that in perspective, a 10 dollar PMPM

(per member per month) cost of care coordination for a provider who has about 50,000 members, totals $6 million per year. If that provider has an average global budget of $375 per member per month, that's almost three percent of their budget. If they're striving to achieve a trend of about five to six percent, that cost of care management is about half of their trend. An integrated delivery system, as I mentioned earlier, reported spending a hundred million dollars in investment in integration and coordination care and largely for IT deployment across the enterprise, but keep in mind that these are not simply one-time expenses or upfront costs, but these are ongoing practice expenses. One large multi-specialty practice for example, acknowledged the investment of multiple millions of dollars over several years to build its care management infrastructure. Even now, that organization spends $11.2 million annually on care coordination plus an additional $3.4 million annually for its electronic health records system. So while we know that care coordination infrastructure is essential, we do not have enough information to say how much spending on care coordination infrastructure is too little, too much, or just right. Moreover, we don't really know the types of medical management programs that deliver the best results. We found that providers did little return on investment or ROI analysis on their medical management programs. We do know that care

coordination requires a minimum infrastructure and that it costs money. The third element that's critically important is data. Throughout our examination, we focused on the data available to help insurers and providers and how such data is used to improve quality care and measure performance. We found significant limitations in the transparency of data in the marketplace to support care coordination. It is important to collect and make data available to among other things, evaluate care coordination efforts and determine which of these efforts and at what cost deliver the best return in our investment as a system. To further discuss the importance of data, I will now turn it over to Doctor Freedman.

John Freedman

Good morning. My name is John Freedman. I provided expert consultation to the Attorney General's office in health care quality measurement through the course of this examination. I'm a physician, Board-certified in internal medicine, and I've also earned an MBA in health systems. My first formal position in quality measurement and improvement was at Kaiser Permanente beginning in 1993. I've worked in a variety of settings since then and I'm currently Principal of Freedman Healthcare LLC, a

firm that consults to providers, payers, government entities and others on issues of health care performance, measurement, and improvement. I assisted the Attorney General's office in quality analysis and performance measurement and its examination. Today, I would like to discuss our evaluation of Massachusetts provider groups and findings that resulted. First, I'll outline methodology of our analysis of selected provider organizations and how they coordinated care. Second, I'll discuss two ways in which data is critical -- first, to the provider's ability to coordinate care and secondly, to providers and policymakers to be able to measure the system's success. The AGO studied 16 provider organizations representing a range of sizes, scope of services, clinical and legal organizational structures. The groups were organized in different models, including a PCP only practice, large multi-specialty groups, independent practice associations, physician hospital organizations, and physician networks corporately integrated within hospital systems. To examine the quality of Massachusetts physician groups, I sought information that reflects performance relative to each other and to national benchmarks. The best such measure is NCQA, the National Committee on Quality Assurances, Healthcare Effectiveness Data and Information Set, HEDIS. HEDIS has been in use for 20 years and HEDIS measures are widely used and accepted within the industry. In Massachusetts, we're fortunate that

Massachusetts health quality partners, MHQP, has published physician group HEDIS performance for a number of years. We obtained MHQP's HEDIS data for 2009, the most recent year available, which includes 24 HEDIS process of care measures. I aggregated these scores into a case mix adjusted average performance for each physician group, and then compared them to the national average performance on these same measures. In reviewing the data, I find that Massachusetts physician groups performed well overall. Only one out of 74 groups was below the national average. Of the 16 provider groups that we examined, all performed above the national average on HEDIS. There is no single or nationally recognized deposit measure used to evaluate whether a provider has successfully coordinated patient care. HEDIS does not explicitly measure care coordination, but for many measures, performance is dependent on coordinated care across specialties and over time. I created a care coordination subset of these HEDIS measures by aggregating scores for eight of the 24 available measures that I judged to be most dependent on care coordination. For example, I included colorectal cancer screening, since it typically requires coordination between primary care and the gastroenterologist. Breast cancer screenings, as it requires coordination between primary care and radiology, and long term medication management in depression, since it requires at least longitudinal monitoring by the PCP,

if not also coordination with behavioral health specialists. Other measures I included were screening for cervical cancer, yearly follow up for certain medications (anticonvulsants, ACE inhibitors, and angiotensin receptor blockers, as well as diuretics), and comprehensive diabetes care, which includes glycohemoglobin testing, cholesterol testing, and testing for kidney disease. I reviewed the performance of the 16 select physician groups on both overall HEDIS measures and care coordination. I compared the scores based on organization size, as measured by health plan member months, whether the organization was physician or hospital-based, and whether the organization's part of the corporately integrated health system. I found that the performance of the 16 groups varied independently of these organizational characteristics. For example, the largest groups among the 16 performed similarly to the smallest of the groups for both overall HEDIS and the care coordination subset. Those groups that are organized as integrated health systems were physicians acute hospitals, sub-acute facilities, are within the same corporate entity, similarly were not significantly different from their peers in their performance nor was there any difference seen between groups that were physician-based versus hospital-based. Physician group performance on quality and care coordination measures demonstrates that no one model of organization or size

is necessarily better than any other. In my opinion, a group in any of these models, whether physician-based or hospital-based model, an independent practice or corporately integrated health system could succeed strongly with high quality and coordinated care, as long as they have certain necessary resources available to them. There are data though that are required. Based on this examination and consistent with my professional experience, primary care providers are essential to the delivery of coordinated care and PCPs need data. PCPs need access to certain information about their patients to best manage their care across the continuum of their health conditions and health care services provided to remedy those conditions. Even a PCP in a practice with an advanced electronic health record would not know, for example, whether her patient has filled a prescription or seen other practitioners or received other services outside of the practice group. Care coordination requires access to such data which is currently limited. Although health plans collect this data through claims, physician groups typically only receive information from health plans when they are in a risk-based contract for their HMO patients. The ability of providers to coordinate care would be greatly enhanced by access to claims information for all of their patients. If health plans shared all that data on utilization and cost of services rendered, regardless of insurance product, it would advance the

opportunities for care coordination to result in better quality and lower cost care. Further, the Massachusetts all-payer claims data set, APCD, went fully developed by the Division of Health Care Finance and Policy, conserves an effective vehicle for the dissemination of crucial health information about patients to their PCPs. Other helpful information and data -- based on my experience in health care, there are key forms of information that would be useful to providers and should be considered by policymakers and others to measure systems success. First is utilization data. Standard use rates of health care services help practices track their performance and benchmark themselves against others. Rather than focusing on individual patients, utilization rates emphasize the overall effectiveness and efficiency of the practice in caring for their entire patient population. For example, rates of medical surgical hospital admissions or relative use of emergency department visits compared to PCP visits, and specialist visits compared to PCP visits, all give indications of both the expense incurred in caring for patients and the effectiveness of that to coordinate care. These, and other utilization rates, could be made available and would serve to educate and inform practices of opportunities to improve their operations, to provide more patient-centric and effective care. In addition, such information would be important to policymakers in tracking the

efforts of reform efforts generally. Second, site of service data. At present, PCPS do not easily know when their patients are obtaining care outside of the PCP's provider organization or preferred referral circle. Health insurers typically provide such referral patterns or site of service data, which can include information on the cost and volume of care going to other providers, only to providers who are at risk. Managing patient referrals is one way to help ensure high quality and lower cost care. Referral of site of service data can help a PCP refer patients to lower cost providers and can improve coordination by insuring the care is provided either within the PCP's organization or by other organizations and provided with whom the PCP has a strong clinical relationship. Consumers, as well as providers, should have access to transparent information about high quality lower cost sites of care. Third, practice pattern variation. One problem that has been identified in health care delivery is the degree of variation in how different providers treat similar conditions. These practice pattern variations arise from a lack of standardization of care for many conditions, but also from a lack of feedback to practitioners about how the care they provide compares to that of their peers. As a result, common conditions may be treated in very different ways, which may result in unnecessary variations in cost, efficiency, and effectiveness of care delivery. Broader sharing

of clinical information with analyses of practice pattern variations deserve greater emphasis as we seek new ways to improve the delivery of health care in an efficient and cost-effective manner. If our health care system as a whole is performing well, we should expect to see decreases in the unwarranted practice pattern variations over time. Number four, quality. Enhancing value in health care requires a tracking of both the cost and the quality of care to our citizens. In particular, if coordinated patient care is our goal, we need to develop better measures of care coordination. The care coordination measures subset that I created and used to analyze physician groups for the AGO analysis, is a reasonable indicator of how groups are providing care across and between settings, but we need to develop standardized measures of care coordination as well as apply measures of long-term health outcomes to confirm that our system-wide efforts are succeeding. We need to track the long-term outcomes of patients. That is, avoidance of death, avoidance of complications and ability, and increased physical and behavioral functioning to truly understand what value we get from our health care dollars. We must continue to support the science of measurement to move from process measures to these outcome measures and the risk adjustment that they require while we move ahead with the best measures that we currently have. In summary, the AGO's analysis

is valid and findings are sound. The data that I reviewed supports the AGO's finding that a variety of provider organizations can deliver high quality coordinated care regardless of whether they are physician or hospital-based, corporately integrated, or of larger size. In my opinion, both primary care providers and transparent reliable data are essential for care coordination. Finally, we should develop additional measures to measure system performance. Thank you very much for the opportunity to present this testimony.

Lois Johnson

Thank you Doctor Freedman. So some key takeaways based on our analysis, we found that no one type of provider organization is better positioned than others to deliver coordinated care, but there are tools that are needed. The data we've seen simply does not suggest that care coordination has to mean consolidation or that clinical integration has to mean corporate integration. We should be careful about being prescriptive in delivery system reform efforts to force integration or the formation of new, larger organizations or give other incentives to providers to size up and take advantage of enhanced market leverage to raise prices and to perpetuate the market dysfunction we've described

in our report. Nor should we limit the choices of consumers to just a few super-sized ACOs. We should maintain options for consumers to go to multiple care providers throughout the Commonwealth of different sizes, different scope of services, and different structures, all of whom can deliver quality coordinated and efficient care. The tools that are needed, as we've talked about primary care as a critical foundation, resources for infrastructure and management are critical. We should encourage consumers to select primary care providers and the system should support PCPs in care coordination efforts. Finally, the importance of data -- data is important to providers, health insurer claims data for example should be widely available. We also need data to measure system change. As we consider how we want to improve the care delivery system to support coordinated care, we need to improve how we measure performance. We need better data and metrics to help us answer the questions of what care management programs have the best ROI, how much investment is the right amount to improve care coordination in a way that delivers real value. Thank you.

Seena Perumal Carrington

Thank you Stacey, Lois, and John. I've received a few questions

from the audience. I'll begin with those for Stacey. Stacey, if potentially avoidable hospital admissions were reduced, how would this impact PPR rates? Isn't the best way to avoid readmission simply to avoid the admission in the first place? I think it's basically trying to get at the interpolate between --

Stacey Eccleston

Between the two.

Seena Perumal Carrington

Preventable hospitalizations and PPRs.

Stacey Eccleston

Yeah. The rate, the way that we calculate the rate, the PPR rate, is just what percentage of the initial admissions resulted in a readmission. So, if we had a five percent -- if we were able to reduce the initial admissions and we had a five percent readmission rate, you could have a five percent readmission rate

before it might result in a lower actual count of readmission, so that would be a good thing, so the actual count -- it might not impact the actual rate, but the actual number of readmissions would be lower, so that would be good. I suppose there could be a scenario too where the rate would go up if you had a smaller base of initial readmissions. If that base of initial readmissions were made up of more severe admissions because the ones you're able to avoid are less severe, that might result in a higher rate, but still a lower actual count, so again it would be a good thing.

Seena Perumal Carrington

Has the division used data from limited service clinics to measure avoidable ED visits or preventable hospitalizations? If not, why not?

Stacey Eccleston

Well, the only data actually that we have available to us to measure both ED visits and hospitalizations comes from the hospitals directly -- the case mixed data sets, so we don't have

data from those limited clinics. There's not a great degree of use of those clinics. If, to the extent that the health care payers are paying claims from those clinics, then eventually when the APCD is up and running, we will have that data and we can sort of look at those separately from hospitals and ER rooms.

Seena Perumal Carrington

I'll turn to Lois. How and why did you choose these 16 provider organizations and what was the study period?

Lois Johnson

We gathered information on these 16 provider groups going back five years. We asked them for detailed information about from their budgets to their quality of performance to their contracts to their...all of their clinical management programs. We looked at numbers of physicians, we looked at how they actually compensate the doctors and how they're paid. We selected, you know, from a range of high quality physician groups. We looked at -- at first, the universe of organized physician groups, so

we didn’t look at the solo practitioners or the [onesey/twosey? 70:25] offices. We looked at organizations. We tried to get a geographic spread across the state, look at some contrasting examples in different markets and try to get a sample of different types of organizational structures.

Seena Perumal Carrington

Many [ERISA? 70:41] providers, mainly large employers, refused to share claims data about their employees, making care management and policy decisions inadequate. How can we address this through the AGO?

Lois Johnson

As I understand it, you’re working with the all claims database to gather information from self-insured employers and we do think that claims for all patients are relevant both to providers and as a system, and we should work to be gathering information on all patients.

Seena Perumal Carrington

And the last one for your office. Is there any evidence that highlights the most cost-effective or highest priority infrastructure investment that integrated organizations must meet?

Lois Johnson

I think our analysis didn't reach that question, but there's ample literature. I think Cathy cited some yesterday about specific projects that have had significant return on investment different interventions. It was hard for us to analyze what, you know, scaling those up across different organizations, but that's why we need more data to evaluate what is the value of particular investments?

Seena Perumal Carrington

OK, thank you. And thank you, all of you. (clapping) So now I'm pleased to introduce Professor Gittell from Brandeis University's Heller School for Social Policy and Management,

talking about the relational coordination in health care.

Jody Gittell

Good morning. Commissioner, thank you very much. I'm honored by the invitation to speak here today and to moderate the discussion afterwards, given the amazing guests we have for that panel. So I'm a professor at Brandeis University and also the director of a new organization, the Relational Coordination Research Collaborative and we're based at Brandeis University within the Schneider Institutes for Health Policy and our mission is to use this concept of coordination to improve organizational performance and outcomes for all their stakeholders. So I'm going to start off by basically agreeing with the previous speakers and the whole tone of the Coakley report, namely that we do need to get rewards and incentives right, and in particular, find ways to reward providers for coordination and not for using that power to drive costs up, but what we also need to do in addition to getting the payment right is know how to build coordination capacity and I think that message came through pretty clearly that you can be highly incentivized to get it right, but you still have to know how to solve this very complex problem. It's not just a matter of

wanting to do it and so part of that I'm going to argue today, is building high quality communication and relationship ties across providers, individual and organizational and then supporting those ties with the necessary infrastructure, some of which we've already heard about. So the agenda's really to talk about briefly what is relational coordination -- it's a concept you'll see that came from an earlier study out of the airline industry, looking at flight departure process, and then explore the impact of that form of coordination on quality and efficiency of care, as well as patient and provider well-being and then explore the elements of the infrastructure that have been found to support the development and sustainability of relational coordination over time. And then just explore briefly, this is a concept that plays out at multiple levels. You can look at it at a very micro level, in terms of patient provider coordination. Seeing the patient is actually a key member of that health care team and the patient's family and community and so on, so this concept of patient co-production, I think, is increasingly relevant as we look to bring down the cost of care, how do we engage with the patient as a partner in that health care delivery process and wellness process? Patients that are in medical homes are another arena for highly coordinated care as we've been hearing, and then at a larger level, linking that together into an accountable care

organization, going across multiple boundaries to seek both efficient and high quality care through high levels of coordination, and we actually have dissertation students at the Heller School at Brandeis, who are exploring each of these and how relational coordination plays a role at these different levels of care delivery. So, this is where I started to get really intrigued by the problem of coordination. I was a doctoral student over at MIT quite a while back and went to Logan Airport, thinking I really wanted to look at a work process where front line workers made a difference, and I was very surprised at the complexity of the coordination involved in something, and this is, you know, far more complex than health care obviously, but even flight departures were fairly complex and a lot of what was going on was not visible to us as passengers, so these 12 groups had to coordinate in a fairly time constrained environment and with a lot of uncertainty, as we know as passengers, weather changes and system issues that make it difficult to predict what the timing will be of the flight departure process, and what I found was that the ties between these groups were really critical in achieving the outcomes and doing it in an efficient way, so being able to minimize the time the plane was scheduled to be at the gate in order to increase both aircraft utilization, gate utilization, and clearly staff productivity was a key goal as well. So as I

started to have some of these conversations, one of the first was with the Head of Operations at American Airlines who said, this is the most complicated thing we do every day, but most people in top leadership don't recognize it. So I think one of my first lessons was the importance of people in very top leadership positions, the C-suite, to understand and really fully appreciate the complexity of the everyday coordination challenges in their organization, so that things that they do can serve to support and enable that, rather than just seeing it as, oh that's something that just happens automatically. This really is core to effective organizational performance and top leadership should be aware of that and therefore be able to support it. But what I found as I started interviewing at American in this initial study was that communication was really an issue. This was a comment from, goodness a gate agent. Here, you don't communicate. Sometimes, you end up not knowing things. On the gates, I can't tell you the number of times you get the wrong information from ops. The hardest thing at the gate when flights are delayed is to get information. And so I started to ask as I was doing these front line interviews -- you know, are there any airlines that you think do this better? And this was back before I had ever heard of Southwest, but the station manager said yeah, you should check out this airline and they really have a different attitude toward teamwork. And so my

interviews there did reveal some differences. Here, there's constant communication between customer service and the ramp. When planes have to be switched, bags must be moved, customer service will advise the ramp directly or through ops. Ops keeps everyone informed. It happens smoothly. Another big issue was what happens when events change? This is obviously an issue in health care, where there is information unfolding all the time regarding the condition of the patient and so on. If you ask anyone here what's the last thing you think of when there's a problem, I bet your bottom dollar it's the customer. These are guys who work hard every day, but they're thinking, how do I stay out of trouble? So the, you know, the natural response here and in other organizations can be finger pointing rather than immediately moving into problem solving mode, and it turns out that's pretty common, and it's not just an issue with airlines. The more typical comment at Southwest, this was a pilot -- we figure out the cause of the delay. We don't necessarily chastise. Sometimes, that comes into play. It's a matter of working together, figuring out what we can learn, not finger pointing. So I started thinking, there's something underlying these communication patterns that maybe goes a little bit deeper and something about the nature of the relationships across these disparate groups involved in turning these planes around, and at American, one of the typical comments was, 90% of the ramp

employees don’t care what happens, even if the walls fall down, as long as they get their check. So groups tended to downplay or underestimate the extent to which other groups involved in the same organization really cared about, in this case, the passenger or on-time performance, and a typical comment there was also, yeah the pilots really don’t care about this organization. They just want to fly their flights and then go out and sail their yachts, so a real sense of lack of goal alignment that affected peoples’ moral and I’ll argue their coordination as well. And at Southwest, you have a kind of a different sense I was getting from employees. I’ve never seen so many people work so hard to do one thing. You see them checking their watches to get the on-time departure, they work real hard, it’s over and you’re back on time. And as I would move around and just interview people in the station saying, well what are you trying to accomplish? No matter who I talked to, it was typically, on-time performance, get you there safely, happily, and with your bags. So there was a sense, regardless of what your job was, that your goals were similar with respect to flight departures. And something else that really struck me is the extent to which people understood or didn’t how their job fit with other jobs in that same work process. So at American for example, in the ramp, I would ask, well what is your job? Well when the bell rings, we go out, we offload bags, we unload

them, and then we wait for the next bell. At Southwest, you would get a very complicated story about why everything they were doing mattered to everybody else, including the down line station, the pilot, because where they place the bags mattered for both how the controls were set in the cockpit, as well as how well they could offload those bags to the down line station and the weight and balance and so on mattered for the fueling. So, a real sense of not just what they were doing, but why it mattered so much, so that was a clear difference, and the final thing that I picked up was a different sense of respect and status. So this was a common comment at American, and at a lot of airlines I visited afterwards studied also Continental, United, and quite a few others -- there are employees working here who think they're better than other employees. Gate and ticket agents think they're better than the ramp. The ramp think they're better than cabin cleaners, think it's a sissy woman's job. Then the cabin cleaners look down on the building cleaners, and the mechanics think the ramp are a bunch of luggage handlers. So these status issues, they turn out to be very common in other industries as well, including even universities. We have our issues as well, but that was something that probably was the most dramatically different as I went and contrasted this with Southwest. No one takes the job of another person for granted. The sky cap matters just as much as the

pilot. You can always count on the next guy standing there. No one department is any more important than another. So I thought this was an interesting kind of set of hypotheses that relationships are actually shaping the communication through which coordination occurs and that this was happening sometimes in this very positive cycle -- shared goals, shared knowledge, mutual respect across these boundaries, driving fairly frequent, timely, problem-solving communication, but it was very often happening in this other way that's much more common in a kind of [siloed? 83:04] or bureaucratic organization, where you have specifically functional goals that don't refer to a common goal. It's basically sub-goal optimization -- specialized knowledge that doesn't link to a bigger picture of why my specialized knowledge and how that links to other people and perceive lack of respect across these boundaries that together seem to inhibit frequent communication and lead to delayed communication as people didn't necessarily know in a time crunch, who needed to know what and why and how quickly because they didn't have the big picture and finger pointing more so than problem-solving when something went wrong. The main concern was not that we get the flight off on time, but that if it doesn't get off on time, make sure I wasn't the last one touching the plane who would then get pinned with the delay, so that being the concern more than what was happening for the passenger. And so that in turn

tended to reinforce the poor relationships, and it's a cycle that's hard to break out of, just like the positive one can be pretty resilient as well. I called it relational coordination, basically recognizing that relationships may be actually helping to drive these patterns of coordination in ways that were important to understand. So being a student with an empirical kind of bent and also I don't think I could've gotten away with a pure theory thesis at MIT -- actually studied this, came up with a metric which is now included. ARC has just put together, under the leadership of Kathy McDonald at Stanford Health Policy, a whole care coordination atlas and this relational coordination is one of quite a few measures that's in that atlas. It's probably the only one that's this kind of network measure that you'll see, but did this nine site study of flight departures at these airlines, and I measured using a kind of a network survey -- it's pretty straightforward, relational coordination with those six dimensions across these employee groups. Measured quality and efficiency performance using the measures that the airlines themselves used in terms of gate time per flight, full time equivalent employees per passenger in plane, and quality measures that are collected by the DOT -- on time performance, baggage handling errors per thousand passengers and complaints per million, and did a kind of risk adjustment as we would in health care, so the key here was that

relational coordination -- it was associated significantly with reduced gate time per flight. That means you're turning the flight around more quickly, thus freeing up the plane to be more highly utilized as well as the gate -- major capital expenditures in the airline industry, and staff time per passenger significantly reduced with higher levels of relational coordination as well as lower customer complaints, lost bags, and late arrivals. So that seemed to be a kind of win-win solution, and if you just aggregate those outcomes into an equally weighted performance index and scatter plot them against relational coordination, you get this kind of pattern, where you see that even within organizations, Southwest for example, you have a variation in performance. That first one was Chicago Midway, the other was LA, which was their most troubled station at the time. And United 3 was basically the shuttle in experiment that they used to increase their teamwork that worked for a while. So I started to wonder if this matters in other industries, and of course health care is very important, but the reason I thought of it at the time is that I was in the hospital having a baby and it looked really familiar, you know, these really good clusters of communication among people who were in the same discipline and then tended to get this breakdown across and I remember the nurses were doing these amazing handoffs. I was at Portsmouth Regional Hospital up in New Hampshire where I

live, and I said, have you been working on your coordination? Oh yeah, we've been doing TQM, we're really pleased with how it's going, and then I said, when's my doctor coming? Oh, we don't know. They don't tell us anything. So again, it looked like there was this same pattern that you do tend to find in organizations that still have the remnants of silos and bureaucracy that you get these strong occupational communities that then have trouble communicating across boundaries and of course that goes across organizational boundaries as well. So in fact, the Institute of Medicine -- this was just a couple years after my study began, said the current system shows too little cooperation in teamwork and said each discipline and type of organization tends to defend its authority at the expense of the total system's function. And this was physician leader at the Brigham, Doctor Clem Sledge, who was the Chief of Orthopedics when I came in to do this study. He was just stepping down. He said, the communication line just wasn't there. We thought it was, but it wasn't. We talked to nurses every day, but we aren't really communicating, and he was one of the -- people point to him as one of the early physicians, at least in the Boston area, to say this is a really important issue. We need to pay attention to it, and I thought there was something revealing. Over time, as I read this quote again and again, we talk to them every day, but we're not really communicating, and it kind of

highlights the importance actually is the listening as well as the talking, and sometimes the respect can inhibit the listening part, and nurses of course were pointing to the same problem. This is a nurse leader at MGH at the time, miscommunication between the physician and the nurse is common because so many things are happening so quickly. But because patients are now in and out so quickly, it's even more important that we communicate well. So I basically did a similar study in the hospital setting. This is the first study of relational coordination in health care. Looking at orthopedic surgical patients, hip and knee replacements, not the most complex procedure, but one where it was well understood in terms of measurement, and you could see the impact of organizational factors more easily, and this was basically a summary of the findings reported in Medical Care right afterwards, that relational coordination was associated with reduced length of stay, and at the same time, increased patient satisfaction and some significant improvements in clinical outcomes associated with knee replacements -- freedom from pain six weeks post-op and mobility relative to patients receiving lower levels of relational coordination across their providers. And it doesn't seem so surprising to me, but it was surprising at the time, you know -- you've been to pretty progressive physicians to think that what they're doing in the operating room isn't the only thing that's driving these key

outcomes that they care about and so again, helping them get a bigger picture of what's going on. This is a scatter plot looking at the same findings. So what I take away from this is that, you know, really very consistent with what we've heard this morning that the nice thing about coordination is it's one of these fundamental process improvements that enables you to achieve benefits on two dimensions at the same time, improving both quality and efficiency, and not having to just be stuck in this old tradeoff between -- are we going to spend more and get higher quality or are we going to cut corners and get lower quality? But actually helping you push out that frontier to get higher levels of both. And so these findings have been extended to other health care settings, looking at readmits for example, in a medical care setting, Newton Wellesley study of the hospital's program and finding significant reductions associated with relational coordination on readmits after seven days and 14 days as well as lower risk adjusted costs per stay and length of stay and marginally significant difference in mortality. But it also improves outcomes for providers -- the sense that, I guess we can imagine you know, in a workplace, and we all have some of these experiences, where we are working in a context of shared goals, share knowledge, mutual respect. What does that do to stress levels and ability to actually get our work done? And so not surprisingly, relational coordination particularly this has

been explored in nursing, is associated with increased job satisfaction, career satisfaction, as well as their sense of professional efficacy and a reduced reporting of the experience of emotional exhaustion. So there are other ways to do coordination. There's certainly a big focus these days on lean and other kind of redesigning systems, and so this is not -- I don't consider this at all a replacement. You know, I teach ops management. I have a lot of respect for process flow and redesign, but this could be a very useful compliment, so as one CMO told me, we've been doing process improvement for several years. We think we're on the right track, but we're tried a number of tools, and they don't address the relationship issues holding us back, so if you see the technical changes as being complimentary to some of these relational dynamics, the hypothesis is really going to be where the big payoff comes in terms of pushing organizations forward. Why would they matter? Maybe because they provide the underpinnings for these lean strategies and that they enable participants to connect these relational dynamics and enable people to connect and coordinate on the fly and not just doing it through a script, but actually having the shared goals, shared knowledge, and mutual respect, that allows you to adapt to uncertainty in a coordinated way over time. So for example, shared goals help participants to align their actions with each other because they kind of

understand big picture. What is it we're all trying to do here? Shared knowledge enables people to understand not just what they're doing, but why it matters to other people and how they can better feed their colleagues. Mutual respect encourages them to value the contributions that others are making to consider the impact that they have on others and to actually hear what others have said, which is key to communication. And together, those can reinforce high quality communication. This is expected to matter very consistent with information processing theory. These dynamics should matter most and there's some evidence supporting this already. When you have high levels of task interdependence, reciprocal rather than just you know, production line sequential, when you have high levels of uncertainty due to variability either in the environment, in the inputs, namely the patients or the patterns of demand, so you have to have the ability to adapt and not just put it on autopilot, and when you've got time constraints due to either time sensitive customer needs or resource pressures. So all of these factors are increasingly present in health care because often time constraints, having to do something more quickly can feed task interdependence because you don't have time to wait till one thing is done before you do the next thing. Often, things have to be done in parallel with feedback loops between, so all of these things should increase the performance impacts

of relational coordination. So the real question, I think, is what are the infrastructural elements that support these patterns of coordination? So just to review briefly, we've got this dynamic going on between the relationships and communication that together drive important quality efficiency outcomes as well as some benefits for providers themselves, in terms of the ability -- the sense of the ability to get their work done without undue stress and emotional exhaustion. And so how do we support that? And there are a number of factors that have been identified. They're not completely different from the factors that were identified in the earlier study of flight departures, and they involve some human resource issues, as well as the kind of infrastructure elements that were highlighted by our morning speakers. So looking at one that's not often considered, I think in the context of care coordination when we discuss it in these settings, is this notion of looking for people and deliberately selecting people who have what you could call relation confidence. In addition to having this technical expertise, to be looking for people who are going to facilitate a good operation by virtue of the fact and this notion that we heard in some of the hospitals that yeah, some people are selected for teamwork, but often your most technically expert people are expected not to need those skills, and yet you can really waste some of that expertise and really cause dangerous

situations for patients if they don't know how to coordinate with others. At New England Baptist for example, which was one of the highest performers in the surgical area, you've got to be a nice person to work here. We pick it up through their references. The doctors here also sure to know someone who knows that doctor. Nurses like it here because physicians respect their input. We also saw that the physical therapists could be selected for teamwork nurses of course and that the more functions or disciplines in a given setting who were selected for teamwork explicitly looked with that in mind as well as their technical expertise, was a significant driver of relational coordination and in turn, the outcomes of interest -- quality and efficiency outcomes of interest. The second thing is how performance is measured and improved. This notion of moving from QA to QI and heard repeatedly how divisive the QA kind of monitoring and reactive function specific punitive system can be for breaking down the coordination that you actually need to improve both utilization and quality. So just a typical quote -- the quality assurance committee is strictly departmental, strictly reactive, everybody's giving reports to them, nobody's listening to learning, the committee satisfies hospital-wide reporting requirements, but it's not effective. We even have Board members on that committee, but we can't get it to work. They have a bad attitude when they go. It's a lengthy,

cumbersome meeting. And just to give you the complete -- we had plenty of systems that were in transition, but the most radically different was a system incorporated quality improvement, utilization, management, in the same team that was in this case called the Bone Team. And they're looking at system problems and not just looking back to see who caused that particular delay in delay and discharge or who caused that quality issue. It was really looking at how do we understand the issue and move forward? Very consistent with Deming. For those of you who are familiar with the TQM philosophy that you want to measure the process and not the person because then you get a lot better information, less information hiding, and more of a learning environment, where people can move forward in a teamwork approach. Conflict resolution turned out to be both in the airline setting and in the health care setting a critical, but under appreciated dimension for creating coordinated effort across functional boundaries. Because these are functions that are often set at odds and competing rather than cooperating around performance, so just to give maybe an example here, the kinds of conflicts we often have are disagreements about the patient's treatment plan -- what it should be. It can go across all the groups. The other big thing is getting a physician to come up to the unit to be available. We have a formal grievance process if you're fired, but not conflicts among clinicians.

There are no particular processes. We just hope people use common sense and talk to each other. Given the power differentials, that's not likely to happen. In fact, people would say it's more like -- it's a very stressful event to confront someone, for example a physician, on an area of disagreement, and so having those processes in place was a formal process that enables people either to get trained in having those conversations or have a formal structure to go to when a conflict occurs, is a very strong predictor of relational coordination both here and in the airlines. So a couple of examples of that -- there's also the issue of how flexible to make job boundaries beyond licensing requirements and I'll just conclude with this developing of shared information systems because this is one where there is a lot of attention right now and a lot of evidence that having an information infrastructure does assist in coordination and giving people the shared knowledge that they need to make better decisions for patients, with patients. I can spend half my day tracking down patients. I'll hear someone mention somewhere in the hallway about a patient with this condition and they're not on my printout, so I've got to walk on every floor and say, do you have this patient? And they go, oh that patient's on the vascular service, but yeah, I think Doctor so-and-so already operated on him. It's ridiculous. It's not just that people are incompetent.

It’s a very complex setting for information flow. You can’t track down all the physicians here because some of them have their own system. It’s a problem. They don’t talk. It’s a problem. They don’t talk. Independent physicians have their own independent systems. They only talk to themselves. I mean, so there’s a big problem. Some of them are on the e-mail system, some of them aren’t. So this lack of a common information infrastructure was one of the major impediments to relational coordination and the associated quality and efficiency outcomes. Information systems are important for coordination, I think, but right now they’re more a hope than a reality. Our CIO is building a clinical and administrative information system. For automation to work, it’s important to get a format that’s understood across these boundaries and then we had some of our settings where they’d gotten to the point that they were so advanced that they were getting more and more demands for increased automation that they couldn’t keep up with because people were starting to see those benefits and so the real challenge was for the system designers to keep up with the demand from the clinicians for functionality. We’ve been so successful with data entry that we can’t keep up with demand from our providers. So again, the resources needed to build the infrastructure, to support the coordination, to achieve these outcomes that we all agree are critically important and so these

practices together contribute to that dynamic and therefore to the outcomes of interest. So I guess one way to summarize it is you can build an organizational infrastructure to connect care providers within a setting and across settings around the patient, and with the patient. What we don't want to see, I think, in patient-centered medical homes or patient-centeredness in general, is everyone connecting with the patient, but not with each other. Someone was saying the other day at a conference, we hear from patients often, the last thing we want is to be the one everybody's communicating with and then not with each other, because then basically we're trying to manage all these professionals who should be talking to each other. So to make the patient part of an integrated conversation rather than putting the burden on them to manage what could be a very complex ongoing condition. So that is one way to picture. And the one benefit of the RC Metric is you can actually measure the strength of each of these ties and see where are they weak, where are they strong and where you can focus effort in terms of strengthening them. So some of the questions to address, and we have a panelist, I'm sure who are ready to help us address them, we're really looking forward to their remarks. What are the investments that are currently needed to achieve some of these benefits of coordinated care? Who should be paying for those investments? This kind of public/private question, and what are

some of the payment models that have the potential to support the coordination of care? We've looked at global and bundle payments, there's some upsides, there's some downsides, how do we really refine those model and learn from experience to get -- we know that payment is enough by itself, but it certainly can either undermine or support those. I should've mentioned, other elements of the infrastructure that we explored and that were critical for driving coordination were case management and really investing in that, building some form of shared rewards between physicians and hospitals and there doesn't have to -- there's no one model of how you do that, but having some way to achieve that sharing of rewards and costs between members of the health care system. Inclusive clinical pathways that include the tasks of multiple providers to help create visibility and connection across a patient's trajectory of care and we did see -- potentially the PCP plays a critical role. The primary care provider as mentioned here, but in a follow-up study we did to this nine hospital, we followed the patient across from surgical to rehab to home, the weakest link with every stage of care was the PCP. So the potential is there. It's often not realized and this was even in a system. It was Partners that was really trying to make the PCP a pretty central player at the time and yet that was the weakest tie. The only consistently strong tie across all stages of care was the family member who was

coordinating with everybody, and the managed care case manager had strong ties with the case manager at acute and in rehab because they’re basically trying to facilitate the patient getting out. So the PCP has this potential role to play in facilitating across and I think we’re seeing that realization now with attention to the patient-centered medical home, but in many cases, it’s just not yet realized. So I want to introduce our panelists if they are coming up here. Oh, yeah OK. I haven’t met them yet.

FILE CHANGE

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Thank you panelists once again for joining us today. Before we begin, I just want to say that all those comments were Southwest Airline employees, also reflect the viewpoints of all division staff that you talked to for anyone who was here for that presentation, but if all the panelists could please rise. If you could raise your right hand, do you solemnly swear that the testimony you're about to give in the matter now at the hearing will be the truth, the whole truth, and nothing but the truth, so help you God?

All

I do.

Seena Perumal Carrington

Thank you. And please identify yourself by raising your hand if your testimony today is limited for any reason, if there are any restrictions placed on the capacity in which you testify here today, or if you have any conflicts of interest that require disclosure. So seeing none, let's begin then. Great, so my slides are gone, right? OK. All right, I had slides sort of introducing each of you, but we'll hear from your remarks what your highlights are, found each of your comments very useful for today's discussion, so look forward to them. And we'll start with Commissioner Barbara Leadholm of the Massachusetts Department of Mental Health and then move on to Doctor Michael Cantor of the New England Quality Care Alliance and then Doctor Grant from Lahey Clinic, Ray Campbell from the Massachusetts Health Data Consortium and then concluding with Doctor de la Torre of the Steward Health Care System. So thank you all for being here and we look forward to the dialogue following your

remarks.

Barbara Leadholm

Good morning, or almost afternoon. Thank you Acting Commissioner Carrington and thank you for having me participate in this important hearing and discussion. I think all of us -- thank you. All of us are really, personally for myself, hearing the earlier conversation how I hope the panel will engage in the conversation in my remarks, kind of just setting the stage a little bit in terms of where behavioral health fits in all of this. To me, it's very obvious that we must integrate and coordinate physical and behavioral health, as integration is important for many reasons, not the least of which is the cost effectiveness of adopting this paradigm into our health care system. It's long past time that we acknowledge that health care is about the whole person, body and mind. When we say health care, we must include the whole person. In addition to physical needs, we must meet his or her behavioral health needs, whether mental illness, substance use, disorder, or both. As we all know, everyone works very hard to pay for the increasing cost of health care premiums. However, families for example, may find themselves in the position of needing to look for services for

his or her child and then told there is a two to three to four month waitlist to see a therapist or a psychiatrist. As a situation becomes more distressing, and they do not get immediate help, they may bring their child to the emergency department for an evaluation, and whether it was preventable, avoidable, or actually appropriate, we're not necessarily collecting the data to determine, but for those that were preventable, there is a less costly alternative and that evaluation may have been providing the appropriate assessment in treatment in a community environment prior to further disruption and distress for the child and family and then potentially for the system in terms of costs and actually where is the most appropriate level of care. While insurance generally pays for scheduled appointments, they are not necessarily easily accessible and timely. It does not pay for outcomes. It dose not pay for providing the services to a child, for example, in my little example here, that will allow him or her to remain in school, at home, and in the community. Those are additional costs. It does not recognize that possibly a pediatrician was the most appropriate person to make sure that the child or family with a complex need receives the assessment in the right setting and sees the appropriate provider. It does not pay for coordination of care for that child or possibly a person who is elderly or other persons who may have disabilities in meeting

their unique needs, sustaining and maintaining their desire to live as much as they can in the community if they are experiencing for example, a depression, anxiety, or other form of mental illness and substance use. The health care system currently pays for treating conditions, not for treating the patient as a person -- a person who wants to stay healthy and get better when they are ill. Nationally, we know that individuals with untreated mental illness or substance use disorders experience higher rates of comorbid conditions, requiring increased medical treatment. To address quality and cost efficacy, we must assure access, early access, to mental health and substance use prevention, treatment, and recovery services. I wanted to share some startling statistics. One in five children and adolescents in the US experiences mental health problems and up to one-half of all lifetime cases of mental illness begin by age 14. 75% of children with diagnosed mental health disorders are now seen in the primary care setting, making the management of mental health issues a growing part of pediatric practices. The increasing prevalence of mental illness among children, early age of onset and emerging evidence about effective preventive interventions, make a strong case for early identification and intervention. Massachusetts has developed a model for children and adolescents that makes this important connection. It is called the Massachusetts Child

Psychiatric Access Project, MCPAP, and it is funded by the Department of Mental Health and managed by the Massachusetts Behavioral Health Partnership. Piloted in 2002, it is an extremely successful model of integrating physical and behavioral health care, care coordination, and more importantly, early intervention and prevention. MCPAP is a highly innovative program designed for, and by the physicians, to promote inclusion of child psychiatry within primary care. Its hallmark is a payer blind structure that allows the pediatrician to allow MCPAP services, regardless of a child and family's insurance. A team of child adolescent psychiatrists provide pediatricians consultative support to help children with less complex mental health needs. This puts less pressure on limited child psychiatric workforce, as they help children with more complex needs. At the same time, MCPAP consultative teams strive to create a culture of empowerment for pediatricians. This success speaks strongly to the necessary integration of behavioral health and general health across all ages. A commitment to integration and coordination has the potential to decrease the overemphasis on expensive service providers and reactive prices oriented interventions. And this primary care integrative approach to behavioral health is not new. In 1995, the MacArthur Foundation brought together a group of interested scientists and challenged them to nationally make a difference in the primary

care management of depression. This work, known as the MacArthur Initiative on Depression and Primary Care, has evolved into a successful national model that we can look to. We don't need to reinvent the wheel. We can adapt what is already working, and here's why it's so critical. The World Health Organization estimated that depression was the fourth highest cause of disability and premature death worldwide in 1990 and will be the second highest cause by 2020. In most countries, including the United States, the majority of people with symptoms of depression turn to primary care providers for help. Over the past two decades, medical science has made great strides in its understanding of depression. New drugs and therapies are more effective in treating depression, yet the stigma of mental illness continues to influence clinician and patient attitudes towards this illness and ultimately toward the quality of care people receive. With vision and commitment, we could expand MCPAP. We could expand it into the adult arena. We could create this model that is relevant and then actually look at what is the best use of which provider in which part of the system to address the issue at hand. Our first step in accomplishing this might be to open discussions in partner with the commercial insurers, since we know that over 60% of MCPAP users are commercially-insured. We must also look seriously at the benefits of care coordination and I think we've had a fair

amount of discussion about that today and I look forward to a continued conversation, that we can both control costs and treat the whole person. An important article about the study of care coordination from the *Journal of Pediatrics Review* reviews and links how patients and their families, with appropriate services and resources, in a more coordinated way actually can achieve better health outcomes. Their study demonstrates one can save the cost, both financial and human, of more intensive services. For example, this study found that office nurses prevented a large majority of emergency department visits and episodic office visits. Medical homes are a logical place to serve as a site for stronger care coordination. To meet the behavioral and general health needs of people with a medical home, we would provide cross-training of teams of caregivers, joining together their multiple skills and community resource connections, with a focus on improving communication and planning within multiple professions to respond more effectively to medical and non-medical needs. We want to stop paying for non-necessary expensive care and instead pay for effective care. This is called value base purchasing and rewards better outcomes the right care in the right place. One of the problems with the way we pay for care is that it's based on insurance billing codes and not based on what patients need and what physicians or other providers are trained to do. We are locked into a system, where

they are only paid when there is a billing code that represents their interaction with the patient or on behalf of a patient. To assure the inclusion of behavioral health in the transformation of health care, in March, I established a small work group, whose purpose is to review important issues relevant to meeting the needs of children, youth, adult individuals and families with behavioral health needs. Representatives of the work group include Mass Psychiatrist Society, Mass Psychology Association, consumers, the National Alliance for Mental Illness, a connector, child welfare, academic institutions, Mass Health, and other sister agencies. We will be meeting over the next several months to develop recommendations that will facilitate a dialogue within the Commonwealth, culminating in a formal presentation of the findings and recommendations for the governors and legislative consideration. Although there are pilots and limited initiatives focused on approaches about demonstrating the importance of integrating behavioral health and general health nationally, it is critical that Massachusetts creates a credible and strong plan that meets the needs of people with mental health and substance use conditions in any health reform initiatives. We will actually be holding an October 26th forum and at that forum, we will take kind of our recommendations from this work group and ideally have a discussion with a wide range of stakeholders, going beyond the

behavioral health community. We intend to invite people from the business community, the legislature administration, and the medical communities -- provider organizations as well as other stakeholders. And then from this conversation in October, we will develop a kind of additional or final policy paper that will outline the recommendations for the administration and legislature's consideration. Thank you for providing me this opportunity to present this information and I look very much forward to Jody's questions as well as the panel's response. Thank you.

Michael Cantor

Good morning. Thank you for the opportunity to comment on the important issues of care coordination and integrated networks. My name is Mike Cantor, and I'm a geriatrician and the Quality Medical Director for the New England Quality Care Alliance, the physician network affiliated with Tufts Medical Center. the New England Quality Care Alliance, or NEQCA, appreciates the work of Acting Commissioner Carrington and Attorney General Coakley and their teams to highlight the challenges that affect our ability to provide high quality efficient care for the half billion patients our network manages each year. I'm here to share with

you the perspective of 1500 physicians in over 180 practices, who are involved in the daily work of caring for thousands of patients in communities in eastern Massachusetts. Although our network includes physicians employed by the group practices, a tertiary and quaternary academic medical center, a community health center, 80% of our physicians put work in small practices that still provide much of the care in the Commonwealth and across the country. NEQCA's mission is to accomplish the three goals of the Triple Aim -- improving the health of the population, improving the individual patient's experience of care, and reducing the rate of growth of cost. We accomplish these goals through multiple initiatives of quality improvement plans at the network, regional, and practice levels. NEQCA provides the resources needed for an integrated system, including medical management programs, electronic health records, data reporting and analysis. NEQCA is the platform that connects Tufts Medical Center, community hospitals, and community physician practices. Our organization particularly supports two key recommendations in the Attorney General's report. First, all patients should select a primary care provider. One major barrier to accomplishing the Triple Aim is that primary care providers are not given resources to effectively manage and coordinate care for most of their patient panels. For example, patients enrolled in PPO plans, as you've

heard this morning, do not identify a primary care provider, and health plans do not share claims data or quality care information about that population. We agree completely with the Attorney General that patients should be encouraged to select a primary care provider, regardless of the type of insurance plan they enroll in, especially since enrollment in PPO plans, as we've heard, continues to grow while HMO membership declines. Health plans should provide data on PPO members, so that primary care providers and treat and manage patients based on clinical needs, rather than on the type of plan that member belongs to. The second key recommendation in the Attorney General's report is the need to improve infrastructure funding for care coordination. Managing populations of patients requires upfront and ongoing capital investment to build and maintain the necessary teams in information systems. Effective care management requires two broad categories of resources -- people and data systems, and both of these are costly. NEQCA deploys both teams of clinicians and better data systems as part of our new patient center medical home, or PCMH program, to help primary care practices engage and manage their patients more effectively. Our model distributes resources so that primary care providers working in small practices had the same tools as their colleagues in larger practices. NEQCA PCMH teams support multiple practices in separate and desperate geographic

locations. The primary care providers and the team members rely heavily on information technology, including electronic health records, a web-based patient registry that includes quality and claims data, and a web-based care management system that uses predicative modeling tools to identify patients at risk for potentially preventable health care utilization, like we heard about earlier, in terms of potentially avoidable ER visits and hospitalizations. And sure, our patient center medical home program combines the best of high touch with high tech. Although the benefit of PCMH and integrated care management for complex patients is increasingly recognized, we struggle to obtain the resources required to hire the staff and build industry with the information technology tools. However, we do not think that health insurance premiums would need to be increased to cover these costs. The resources are already in the health care system, but are now retained by insurance companies, who usually do not have robust clinical relationships with patients that will allow for effectively providing care management. Although some of these programs may have value, they usually do not collaborate with primary care providers or specialist physicians. How can these programs be effective if their care teams never talk with physicians? Mister Roosevelt of Tufts health plan sent his testimony here on Tuesday, that for every one dollar his plan invests in one of their care

management programs, they have $4.80 return. The Attorney General should have Tufts and the other health plans publicly provide data about expenditures on care management programs, so that we can see what these programs cost, and learn how and if they produce the results that Mister Roosevelt claims. A system that integrates care management directly with patients and their health care providers makes much more sense and that is why in many other states, there are all pair models providing financial support for PCMH and other initiatives to integrate care management, including behavioral health as we've just heard, at the practice level. Simply put, funds collected in premiums of care management should be provided directly to the providers who have clinical relationships with patients and can collaborate on clinical decisions at the point of care. The current lack of funding hurts our network even more than some others because as a low cost provider, we lack the infrastructure money and higher margins, which the higher cost providers enjoy by virtue of having these costs included in their current contracts with payers. Reallocating care management resources to providers from insurers and assuring that all providers are paid fairly for work of equal or greater quality, will enable networks like NEQCA to provide integrated and coordinated care that meets the goals of the Triple Aim. Thank you so much for the opportunity to be with you this morning. I look forward to participating in

the panel.

Howard Grant

Still, good morning everybody. I forgot the hook already. (laughter) It's a pleasure to be here this morning. My name is Howard Grant. I'm the President and Chief Executive Officer of the Lahey Clinic. I've been in the Boston area now for seven months and it's true that it's a very exciting place to be managing health care. I'm a pediatrician by training and honored to be on the panel with these folks and agree with almost everything that both of you have just said and suspect that my colleagues will as well. By way of background, Lahey Clinic is a multi-specialty group practice a tertiary hospital together, with community practices on both the North Shore and in the Greater Boston area. In 1923, Doctor Lahey founded the clinic to bring physicians together under one group, under one roof, so that they can more easily share patient records and treatment decisions. I think it was visionary, since today that there's strong sentiment that integrated practice model is best for achieving the goal for coordinated care for better quality outcomes and greater cost efficiencies. I was asked this morning to talk about examples in my experience of insurer and provider

partnerships that resulted in improved continuum of care for patients that they served. As providers are rethinking traditional approaches to care delivery, it would be fruitful to rethink the traditional roles of insurers and the insurer-provider relationship to encourage more partnership approaches. We need to standardize simplified administrative interactions. We need to share data more readily as you've heard earlier this morning. We need to work collaboratively with each party doing what it does the best. One example is the standard case in disease management model, which we've just heard about, where oversight is done by the insurance companies from corporate offices, rather than support services fully integrated into the front lines of care. It's been shown consistently in fully integrated environments that extension of care management into the clinical arena is more effective, provides considerably greater patient and family satisfaction and is more supportive of primary care givers, ultimately resulting in improved clinical and financial outcomes. From my direct experience, I offer two examples of what can be achieved. When I was Chief Medical Officer at the Temple University Health System in Philadelphia, we cared for predominantly indigent population, with over 50% of our patients covered by Medicaid and a considerable number of patients who were uninsured. With a local Medicaid managed care plan owned by seven health care

systems in the north Philadelphia community, we formed a unique and very successful partnership, where the health plan committed all of its ambulatory case and disease management resources to the hospitals and the physicians themselves. At Temple, we took these resources which historically resided at the health plan and built a superb complement of case disease managers, pharmacists, and other clinical personnel, to support our very challenging population of patients. For a period of about three years, through this partnership, we were able to manage successfully the entire continuum of care at a considerably lower cost than had previously been experienced. The health system actually had surplus revenues caring for a Medicaid population, allowing us to reinvest in our clinical enterprise. When that health plan subsequently pulled those services back to the corporate level and removed them from the front lines, the successes we enjoyed were diminished considerably. Closer collaboration between insurance companies and providers, including a substantive investment by the insurance company, enabled the providers to effectively improve quality and reduce cost. During my three years at the Geisinger, what've I got, two? Three? Great. Three years at Geisinger, three minutes left. (laughter) During my three years at the Geisinger Health System in rural Pennsylvania, I enjoyed a similar opportunity to work in a fully integrated environment. We cared for a large

population of patients covering a 40-county region -- 300 miles northern Pennsylvania. The insurance company, which was part of the Geisinger System, made substantive investments that supported chronic disease management, aggressive development of medical homes, and most importantly, re-engineering primary care practices to better care for chronically ill patients. Recognizing that 80% of health care expenditures are generated by 20% of patients, the health plan hired -- the health plan hired and embedded full-time case managers, 250 of them, in primary care practices across the state. The insurance company also invested in the primary care practices so that they could re-engineer their services and it provided primary care physicians stipends over several years so that the investment of physician time in re-engineering their practices, which reduced their capacity to see the same numbers of patients in the fee-for-service setting, ultimately did not effect their income. Case managers provided 24 hour a day, 365 day per year support for patients with complicated and chronic disease. It was available to the patients and their families. The nurses had a panel of 125 patients and they were available 24 hours a day. We introduce these services at 70 primary care sites. We saw the same results at every single site. We had over a 25% reduction in hospitalization rates for those practices, a 40% reduction in readmission rates for those practices, improved

compliance with medication and follow-up visits, and a significant reduction in overall health care spending as compared to the anticipated trend for a comparable population of patients who did not have these services. In addition, the primary care providers were considerably more satisfied in their practice and gratified by their ability to provide excellent care for their patients and our patients and their families felt much more secure in their continuum of care and the support they received. My experience, the model provided considerably higher quality, greater satisfaction for patients, families, and providers, but it only happened because of the vision and commitment of a true partnership between our insurance company and our clinical enterprise. As much as we need to re-engineer care processes and reimbursement approaches, we need to re-engineer our historic provider insurance relationships to foster true collaborations and partnerships with both parties committed to supporting the other in doing what they're both best positioned to do and using each and every health care dollar effectively for the benefit of the patients that we serve. I appreciate the opportunity to speak today. Thank you so much.

Ray Campbell

Good morning, commissioners, professor. My name is Ray Campbell. I'm the Executive Director of the Massachusetts Health Data Consortium and it's my pleasure to be here this morning to offer a couple of remarks. I submitted written testimony that made four basic points, and so what I'll do is try to give you the quick improv version of that, and then I'll pass it off to Doctor de la Torre. I actually have to say, I've been here for most of the testimony that's occurred so far. I've been really impressed with the caliber of the remarks people have made. When I wrote my testimony, I wasn't sure if these were remarks that others would be making or not, but we've heard a lot of similar comments from other speakers, so I'm gratified to hear that there was clear recognition of some of what I'm going to say. So first, I wanted to make the point that payment reform is a multi-year, ongoing evolutionary process and that's come through loud and clear in a lot of the comments that have been made so far. Outside of this room, I think there's a lot of people that think that payment reform is going to occur with the flip of a switch or the passage of a bill. That will be something like health reform or access reform that there's a very definite point in time at which it starts. I think it's going to be more of an evolutionary competition for hearts and

minds and trial and error process, but I don't think there's any doubt that we're going to be moving away from the fee-for-service system over the next several years and I think that's great news. I think that people predicted that the fee-for-service system couldn't survive past 10% of GDP or 12% or 14 or whatever it is, but finally I think we're at the point where the smart money thinks that there's more upside in the out years in accountable care and value-based delivery than there is in fee-for-service, so payment reform is certainly coming. The second point I want to make, and this has also been made by a lot of speakers, is that data is absolutely central. It's indispensable to making payment reform work. Payment reform is about accountable care. Accountable care is about integration. You can't do integration without data, so data becomes absolutely central to payment reform if we're going to make it work, and I think that, you know, not only do we need data -- I mean, what does that mean? I think we need, you know, certainly IT infrastructure, but it means we need the people that not just operate the IT systems, that use data in their day jobs, that are comfortable with data and analytic techniques and methodologies and terminology, to bring that to bear on the jobs that they do so that they can improve a whole range of processes continuously and I think we need to be aware of how many processes we need data for and about, how many processes need to

improve as we move from fee-for-service to more accountable care arrangements. It's not just direct care and it's not just care coordination. It's care transitions between different organizations. It's risk management, it's patient engagement and outreach. It's supplier -- understanding what you're getting from your suppliers. If you're a health care organization, in a fee-for-service environment that wasn't as important, and in accountable care arrangement, you've really got to be measuring what your suppliers are and aren't giving you. You've got to look at your whole supply chain. So data becomes absolutely indispensable for accountable care and it's across the entire health care enterprise. It's not just as the bedside, so we need to realize that and we need to start doing something, I think, about that and that brings me to my third point. I think data and analytics will clearly be and should be in some ways competitive differentiators for health care organizations. They will compete as is true in every other industry in this country, where if you look at the market leaders, they're primarily analytic competitors. They're in a leading position not because they have some patent that others can't produce what they're producing, not because they have some, you know, real estate location that occurs can't compete with. It's Wal-Mart's analytic abilities that make them the leader that they are. It's Dell's analytic abilities that make them the leader that

they are. So certainly, health care organizations will be engaging in competition based on data and analytics. I think that's a good thing, but I think we also have to realize that there is a non-competitive dimension as well, or that there needs to be, that there's a community and a cooperative dimension because we are a health care community and because people do travel between different organizations, and so there has to be a community layer and a cooperative layer, as well as a competitive layer as we think about data and analytics. And that would bring me to my fourth point, which is that I think we need, and I hope all of this leads if not inescapably, at least naturally to the conclusion that we should be investing more in data and analytic infrastructure in the state. And I think that, you know, first and foremost, we need sustained and substantial increases in appropriations for the Division of Health Care Finance and Policy, and for the health data functions within the division of the Department of Public Health, the Executive Office of Health and Human Services, and the other parts of the OHHS that handle data. We need to be doing a better job, I mean, they're doing a great job with what they've got, but we need more resources for those functions in state government. We need to be investing more money in private data infrastructures, but that's to the private organizations, as we'll hear, some really interesting things about how Steward is approaching, you know,

IT and data infrastructure. If not hearing that today, they certainly are doing a lot of really interesting things in that area. Forgive me, I lost my train of thought for a second. Oh, so investing in public data infrastructure and investing in private data infrastructure, but I think we can't overlook multi-stakeholder cooperative infrastructures. Organizations like Mass Health Quality Partners, and we've heard them mention a number of times so far in these proceedings -- organizations like the Mass Health Data Consortium, but I don't mean organizationally specific. I think just in the idea of multi-stakeholder collaboration around data sharing is something that we've got to get serious about as a community and as a Commonwealth, so I think investing in those things and then lastly, I think we need to invest, and not so much financially, but in terms of thought and leadership and public/private data structures, the state collects an enormous amount of data from private health care stakeholders. The state provides some of that data back to private stakeholders. I think we can come up with much better methods for public/private cooperation, both around the submission of data to the state and around access to that data, not by any and all comers, but if we can't recognize that licensed and regulated Massachusetts health care provider organizations and Massachusetts payer organizations are different than just man on the street types of requestors, I

think we need to come up with structures that allow for at least our payers and providers to have much better access to state data. And with that, I'll turn back my remaining minute. (laughter)

Ralph de la Torre

Thank you. I thank the Division and the Attorney General's office for inviting me to speak. So while Massachusetts is a national pioneer in the area of health care access and quality, it lags in the area of cost containing. In fact, Massachusetts leads a world in health care spending. At the heart of the issue is a general misconception that has led to an erroneous approach. Discussions around health care have long centered as they rightly should have on the application of public health policy. How do we immunize children? How do we prevent the spread of malaria, of AIDS? Times are different. Health care reform in Massachusetts is no longer primarily an exercise in public health policy, but rather an exercise in public finance. As an exercise in public finance, the process to lower cost and improved health care delivery, must be methodical and implemented over a period of time. In other words, it needs to look more like a business plan. As such, in order to lower the

annual growth rate in cost, improve care coordination and achieve clinical and financial integration concurrently, the system must adopt a long-term business plan approach. First, let's understand and discuss the factors driving cost. The cost of health care has two fundamental components: the cost of a unit of health care, an X-ray, a procedure, or hospitalization, and the total number of units of care consumed -- utilization. These two combine to construe what we call total medical expense. Break it down a little more. The unit cost component is comprised of supplies, fixed costs and labor costs. Hence, controlling an individual hospital's expenses can be achieved primarily by driving down supply or labor costs. A hospital operating efficiently, and this will be a topic for discussion, can decrease the unit cost mainly through layoffs or at a minimum, cutting supply costs. While opportunities exist in maximizing hospital efficiencies, these improvements, at least in community hospitals, are not the Panacea many might think. Another component of unit price is profit. Profit is defined as the difference between the cost of providing a service and the cost transferred to a payer. While attacking hospital profits may be of interest to some, it is not the solution to lowering costs within Massachusetts community hospitals. In fact, according to the Division of Health Care Finance and Policy’s latest hospital reports, the average Massachusetts community

hospital made a median operating margin of approximately 1%. This small operating margin makes it nearly impossible for community hospitals to make the infrastructure investments needed to achieve clinical and financial integration. It is only through clinical and financial integration that both efficiency and utilization can be addressed. For most Massachusetts community hospitals, cutting unit price would have dire financial consequences. Many community hospitals would be left without the resources to engage in meaningful health care reform. In a system where profitability is necessary to support infrastructure, a mandated decrease in the per-unit cost has a different effect. When an outside force acts to lower reimbursements on the unit cost side alone, the health care system compensates. We saw this in Medicare on the physician's side. It compensates to maintain profitability through increased utilization. The resulting effect is an increase in total medical expense and higher costs to employers and consumers. Furthermore, if we look at efficiency, to affect efficiency-driven costs, it is important to understand where opportunities exist. In Massachusetts, over 40% of hospital provider dollars goes to 6 of 65 hospitals in the report and over 60% to the top 13. If a considered effort to decrease cost on the heels of efficiency measures is undertaken, we must first understand and address the issues of this sub-group of hospitals. While

increased efficiency can have an impact on the per unit cost of health, it is not the real opportunity in this category. The true opportunity in controlling the cost per unit of health care exists in managing and coordinating the location of care. Generally, care is delivered in four broad settings: 1) Academic tertiary/quaternary providers, 2) Community hospitals, 3) Physician offices and 4) Home based services. With up to a 50% difference in cost between each of these categories or settings, shifting care to the appropriate setting is the obvious way to lower the per unit cost of health care. Maximizing efficiency and providing care in the appropriate setting are ways of lowering the per unit cost of health care. These steps, however, do not address the issues of our future, simply the issues of our past. History has taught us that Generals too often prepare to fight the last war and not the next war. We cannot make the same mistake. Controlling health care costs in the future is about understanding and managing the utilization of services. Simple math shows that one time decreases in cost simply shift the cost curve, but do not affect the change in total medical expense over time, otherwise known as our Budget Trend. In an aging population that will utilize more health care, we need to aggressively pursue controlling the consumption of care. The answers are before us. Providers need to build an infrastructure that coordinates, manages, and integrates care.

We have the resources to build the appropriate IT platform, or we need to have the resources to build the appropriate IT platforms, quality system, care integration and coordination. Whether you call it an ACO, an HMO, a Patient Centered Medical Home, or any other acronym, this level of clinical and financial integration is the future of successful health care delivery. Lowering the annual growth of health care must be an incentivized process embraced by providers, not an imposed mandate. More importantly, such incentives must reward providers for delivering integrated, high-quality care in lower cost, community-based settings, where the cost of care is affordable and will drive lower TME. In this way, we capture the immediate efficiency driven games of the price per unit, but more importantly, create an infrastructure to sustain and improve upon these savings over time. With this context, a question of how to lower the Budget Trend, improve care coordination and achieve clinical and financial integration becomes approachable. The answer, providers must adopt and government must support and encourage business plans -- not short-term change, business plans. That enables providers to maximize administrative efficiencies, build adequate infrastructures to effectively manage and coordinate care, shift and coordinate care to the appropriate value-driven location, and adopt a long-term value-creating business plan. In order to achieve this paradigm, the

following elements we think are necessary. One, aligned guiding principles -- principles that prioritize patient care and quality outcomes in community-based settings much drive the mission and the care model for providers and payers alike. Two, robust information technology infrastructure -- Steward has invested over $100 million to develop and implement an integrated, system-wide information technology structure that supports and aligns our network of care. An integrated IT platform is central to the success and ability of an integrated model to deliver cost-efficient care. Community-based networks of care, three -- provider systems must meet the needs of the local community and keep care local where it will help improve the overall health of the community, lower costs and improve employee productivity. Four, financial integration and accountability -- an essential component to any successful model of integration are the tools used to go through ward providers, measure the performance, hold them accountable for meeting outcome-driven goals, that improve patient care and lower total medical expense. And last, but definitely not least -- quality and clinical integration. It is a fundamental element and critical to the future of health care. Steward defines integration as an accountable health care that provides high-quality, cost effective care, through an integrated and inter-connected continuum of providers across geographies, homes,

offices and hospitals. The divisions focused on lowering costs must consider ways to encourage providers to simultaneously build adequate infrastructures to effectively coordinate care and to establish a trusting relationship with patients. To that end, Steward is focused on lowering total medical expense, both unit price and long-term utilization, i.e. budget trend, and on enhancing its clinically and financially integrated model to deliver care in community-based settings. Steward leverages global payment arrangements as one tool to drive quality and lower TME and foster cultural change within the payer and provider community. The future of successful health care delivery depends on providers transitioning toward payment models that appropriately hold providers accountable for improving community health, promote wellness, lower cost, and proactively focus on keeping patients healthy over long periods of time. Thank you very much.

Jody Gittell

All right, thank you to everybody for their remarks. I had the benefit of reading them ahead of time, so I had a chance to reflect. I'm sure everybody else feels that they've just been hit with a lot of really interesting perspectives and

information. So I'll start by asking some questions and in the meantime, we also got -- (pause) we also got questions from members of the audience, so thank you. I just wanted to start with one area of agreement that I think I've picked up across all the panelists, and there was more than one, but there's pretty much agreement on the nature of the infrastructure that's needed to ensure coordinated care in a way that leads to efficiencies and quality of care over time. I'm not sure though, if there's agreement regarding who should pay for that. Who should make these investments and I know this becomes the theme of the afternoon, but what is the right mix of public and private contributions to those investments and you can just -- we can go left to right. I mean, it's really a question for everybody. Right to left?

A

Well, you know, I think there is no one construct that's right for any hospital or any system. I think it depends on the individual providers and the populations that they serve, their financial means, et cetera. So I think for example, hospitals with very good payer mixes that have different levels of profitability, bear the burden more as providers and systems

that have more government and public patients that cannot manifest the profitability to actually drive that infrastructure should have the systems from the private sector and public sector.

A

I agree with all that certainly and I think another slice, another way to look at it, is to look at it from aspects of the infrastructure that organizations can be expected to provide themselves, versus things that can only be done on a multi-stakeholder basis, so for instance, if you wanted a database that showed you hospitalizations on a semi-real-time basis, if you wanted to know when patients had been hospitalized -- that's not something that any one organization can solve for on its own. I mean, it's not practical to imagine them contracting with every other hospital in the state and setting up real-time communication, so that would potentially be the type of thing that would make more sense as a community utility, so I think that's part of the discussion, is identifying things that really aren't effectively done or can't be best done by individual organizations. If it can be best done by an individual

organization, then it's their responsibility, I think, between them and the payers to finance it.

Jody Gittell

Right, that just reminds me that kind of related to this question is this notion that data is a serious source of competitive damage, but also is something that could be viewed as a community or common resource and where to draw that boundary, and that's basically -- you would suggest, it's those areas that you literally can't form that database on your own, or you may be able to do it in partnership with other members of your integrated delivery system, but at some point, you would turn it over to a public agency.

A

Sure, I think there's certain foundational information that you can't do accountable care unless you know when people have had encounters with the system and if there are ways that you can do that without, you know, some sort of a community approach to gathering that information, then fine, but I'm not aware of what

it is. Total medical expense is another thing, where it's very hard for one organization to understand, you know, when their patients have had an interaction with another provider, but just what the cost implications of that are, which becomes very important in a world of accountable care, so you know, I think that we first, at least in terms of community responses, we should be looking for those services and data sets that can't be provided in any fashion other than through collaboration, and we need to start having a strategy for how we'll collect those.

Jody Gittell

Right. I'm just going to throw that right back to Doctor de la Torre and then continue with the other panelists, but given the substantial investments, at least it's been acknowledged that you've made in information systems, is it equitable or fair to have public provision of some of those data or is it really a totally different realm, do you see that clear distinction?

Ralph de la Torre

Yeah, so I mean there's two components of the infrastructure, right? One is the IT and we've all, you know, discussed that. And you know, I think some of the data does exist, you know, through very tight relationships with payers. We get a lot of prospective and fairly real-time data around the claims data basis for any kind of authorization for admissions or for hospitalizations, so we can track that. Since we are at risk for almost all of our commercial products, we actually do get pricing data on just about everybody, so we know how to move it. It's something that's aggressively shared with our physicians, who are really the central focus. What group is the doctors? They actually have the majority of the board, and everything goes through our physicians. You know, the real key is not data, but having -- well let me take that back. Step one is having the data. Step two is having the infrastructure underneath it to know what to do with the data. And then once you know what to do with the data is kind of getting by it. You know, the provider network, be it hospitals and physicians alike, you know, it's like herding cats. So you know, getting them all on the same page is the third and critical component of it. Most of us don't view it as competition. I mean, we've done what we've done because we needed to provide a service for our

patients and you know, I think there are hospitals, and I'm not going to say any to point out, but who need help because of their care mix to provide that data infrastructure, and I don't think anybody would be grudged on that.

Jody Gittell

OK, Doctor Grant.

Howard Grant

I think it's safe to say there isn't new money for the system and so the question is, how can you align the incentives appropriately so that the stakeholders are making appropriate investments, so that people have the tools getting back to your question, how are you going to provide that resource? And in the example I gave earlier about how we address primary care in medical home and my previous environment, the insurance company provided all of the infrastructure, with the understanding in the shared risk arrangements that the insurance company would be paid back for their investment with the original savings by providing care. And then subsequent to that, there was a shared

savings between the insurance company and the providers for having reduced the expense of care. So everybody was lined up in the same direction. You're never going to be able to get hospitals that are operating with 1% margins or private physician groups to make an investment of the magnitude that will be necessary to realize the type of opportunities that are out there for cost reductions. Just to give you an example, Ralph you talked about $100 million investment in Steward. In a comparably sized system, we had made a $120 million investment in the system installation, but we made a commitment as an organization for 5% of our revenue, or over $100 million per year, in support of our electronic year.

Jody Gittell

Was that at Temple or Geisinger?

Howard Grant

Temple.

Jody Gittell

Temple, so this is a --

Howard Grant

No, no, no, no, no. At Temple, we had paper and pencil.

Jody Gittell

Yeah, you said it was a much lower resource system, yeah.

Howard Grant

No, no, no. But the point was because of the integration that we enjoyed with our insurance company, we were able to markedly reduce the cost of care. The savings that were realized in the insurance plan all got reinvested in the clinical enterprise and it wasn't negotiated. We were an integrated system, so decisions were made that were best for the patients whatever the issue was. But the point was that the case managers and the re-

engineering of the practices and the additional stipends for the primary care docs, so they were able to markedly improve the quality of care and markedly reduce the cost was all upfront from the insurance company, and they made the bet that there would be such significant reductions in expense that they would be able to recoup that plus substantially more, and as I said earlier, we did it every single time in every single practice -- significant savings. But it wouldn't have happened had not the insurance company been willing to make that level of investment.

Jody Gittell

Right. Right, so I thought that was intriguing, as well as this notion by Doctor Cantor of reallocating some of those care coordination dollars from the insurer to the providers. Here, it was done in a more cooperative way. How would a state -- say the state of Massachusetts, encourage or facilitate that happening if it's such a beneficial arrangement?

Howard Grant

Well I've had that conversation with the CEOs of all the health plans and have challenged them that if they want to see a reduction in the expense and they want to improve the quality, they're going to have to make investments. It's challenging because I assume most primary care practices have a disparate mix of patients from all different insurers.

Jody Gittell

Right.

Howard Grant

And you don't want to put providers in the position of having to say, well I can do this for this patient, but I can't do that for that patient.

Jody Gittell

Because we don't have an agreement with their payer.

Howard Grant

I think we need to have demonstrations, pilots, where the commercial carriers and the state come together, and say for a discreet population of patients and practices, we're going to provide this infrastructure to the practices and demonstrate what I can assure you will be the result. There will be significant reduction in the expense. People will recoup the investment that they've made, but more importantly, we will be delivering considerably better care at considerably lower cost and providers will be much more gratified in the way they're delivering care to their patients.

Jody Gittell

Right, so if you would just expand a little because I know a bit the story of how Geisinger's accomplished it, but how did that

happen at Temple, where you didn't have that same partnership built in?

Howard Grant

But we did have the partnership with the insurance plan and until such time as the other six owners of the plan were resentful of the fact that Temple was making money on a Medicaid population because we were so efficient in the way we were managing the care, and they pulled the resources back to the corporate level, we were demonstrating that if you make that investment and you put the resources into the practices, that you can markedly reduce care in the most challenging populations.

Jody Gittell

Right, but it wasn't enforceable in the sense of keeping it in place, even though it was beneficial in many respects.

Howard Grant

That's correct.

Jody Gittell

Yup, OK.

Howard Grant

So the question you ask was, what could the state do?

Jody Gittell

Yeah, and maybe fun demonstration projects to show that it works, but then yeah, and that it works for all parties perhaps, but let's go on to Doctor Cantor, who had similar thoughts.

Michael Cantor

I think the strip down of what Howard had been saying, is that when you have care management, it's based in insurance companies. It doesn't work as well on spaced primary care practices, especially --

Jody Gittell

Because it's not as well informed?

Michael Cantor

It's not integrated, and it's not rocket science. Like you know for this population of patients, you stratify the population, you identify the high-risk patients, you then target care management resources around those patients -- it's what you do in the Division of Mental Health. It's what we do in NEQCA today. It's what you've been doing in other places. Everyone at this table has been involved in that mis-stratification identification intervention approach, that we know works. And we know it works better when you have to go back to your

original presentation, when there're good relationships between the people who are doing the stratification and the interventions.

Jody Gittell

Right, as opposed to having a punitive outside party telling you what to do.

Michael Cantor

Correct. So when clinicians who know each other work together, the results are better for the clinicians and for the patients in the costs and quality improve. We have examples of this, you know, this challenge. You point at this head-scratching. It happens every day in our practices because we do have differential payment relationships with the payers and some of them give us most resources than others and so we see this problem, and that's what we want to do, is eliminate that problem. We believe that everybody -- all the payers, whether it's the state, the federal government, the private payers -- all through we have to figure out how we take the resources that

are currently not being allocated to providers and patients directly and redirect them. And if they're not, then they don't exist because in a fee-for-service Medicare environment for example, that money isn't sitting there. What we know is if we do this stratification intervention approach, we create the funds that allow you to continue to reinvest in the data systems, in the people, to actually make it work.

Jody Gittell

Right, so this is not a one-time fix. It's a dynamic feedback loop.

Michael Cantor

Correct, and one size does not fit all and I think that that's the other clear message. Our practices are very different than Lahey's practices that are different than the Steward practices. It's not only the size of the practice. It's the culture within each practice and within each region and within each town that has to be addressed and the process therefore has to be customized and tailored and it's about local leadership and

community-level intervention to make sure that communities of physicians and patients and nursing homes and home health agencies and hospitals, that we're all working together literally on the same page. To go back to your point about relationships and relational coordination, that's what's lacking today, like it's pretty clear that the more we build systems that look like coordinated systems, we're going to be more successful and that's really the point that we see, is we just want to be able to have that opportunity to use those resources for our patients and with our patients to accomplish higher quality care at lower cost, and we know, from examples like guys at Temple, in many other places now that can and will work when done properly with proper resources and leadership.

Jody Gittell

Right, so you don't necessarily know how to either enforce that sharing of care coordination funds from the insurer or make it attracted to the insurer, so they see how they, too, benefit down the road, but there's at least some common theme here, and it looks like we may have some disagreement here, but let's hear Commissioner Leadholm. How do you see this?

Barbara Leadholm

I certainly don't want to just duplicate what I think were some key perspectives. I think coming from more the government side, I think our role is much more in-partnership, and I do think I've heard that loudly and clearly this morning -- is there a way we can partner that where not one has greater or less say, but that we come together as partners, assess really what is the basic foundation, and for me, I'm going to be saying, and where does behavioral health fit in any of this? Because know that the data on behavioral health is not always of the same quality or caliber that data in more kind of general health is, and so then I would like to, for example, Health Care Finance and Policy to say OK, how do we bring all this together? We've agreed these are kind of the basics or the foundation of the data that we want to collect, and I think unfortunately, the state collects a lot of data. How we analyze it is not necessarily improving the system in terms of where the gaps -- we certainly know people cycle on insurance. Certainly a lot of people of the working poor, they're on Medicaid, they're off Medicaid, and so I'm most interested in how do these various data collection -- whether you're a provider, whether you're an insurer, who's investing in it, whether it's the state -- how do you bring them together?

And I think that's a key role that government plays in terms of saying, here's the foundation in partnership with everyone else in terms of interested parties. So we have our foundation. How do we integrate it and then do we provide, maybe, in the state that integration through software? Not that we legislate, this is how you collect data or this is the system or this is what you need to do, but rather bring it together and really facilitate that conversation and then use the data, so that we're looking system-wide because it is important for individual communities, individual providers, accountable care organizations, whatever, but who is going to bring it together ultimately?

Jody Gittell

Right.

Barbara Leadholm

And I think that's the state role.

Jody Gittell

Right, so the state role could be to create this common data infrastructure that allows the systems to connect. I remember when I switched from studying the airlines to health care, I was shocked and dismayed by the lack of publicly available data. I just took for granted that I could look at the operating costs of every airline that every operated in the US in great detail and not to mention, quality outcomes, but that's something that may start at the state level, but certainly goes beyond the state as well. So that being a particular place where the public investment may make a real difference without preventing people from competing then on the basis of how they use those data and how well and effectively they can use those data to coordinate care. Ray, you wanted to respond?

Ray Campbell

Well I wanted to elaborate on something which I think many of us are thinking but not saying. First of all, something we may not all agree with. I think that grants for infrastructure cannot be upfront, or else you end up with a lot of computers that are glorified paperweights, so there needs to be meaningful use and

backend money, but the upfront money needs to come from, you know, the providers. So how do you make money available for providers? Because they have to go to borrow and come up with the money on the first. While we're overlooking a fundamental change that is going on in the market, which is payment reform, as many of us embrace payment reform, it fundamentally changes the actuarial risk profile of the payers. Therefore, their reserves are now liberated, quote-on-quote, and the reserves are less than what they necessarily need. So why don't use those reserves that have -- that are now, quote, liberated, as we take on more risk to create a fund to potentially fund the infrastructure for hospitals.

Jody Gittell

We, being hospitals individually, individual systems, or?

Ray Campbell

No, I mean the state comes up with an actuarial methodology to evaluate what the risk reserves are required and how to treat shared risk payment reform models. So for example, if I'm at

100% full risk for every patient in my network, then why should the provider need a huge reserve to cover that patient? It doesn't because we're duplicating reserves. I've got a reserve, they've got a reserve, so if I'm taking that risk, then their reserve can be potentially mobilized to meet the infrastructure needs of hospitals. Put it as a fund, hospitals can borrow against that fund and then pay it off through meaningful used dollars.

Jody Gittell

And the hospitals borrow from.

Ray Campbell

We create it as a fund, or you know, really all insurance companies are public charities. Isn't that wonderful? (laughter)

Jody Gittell

Interesting. So you're talking about what kind of investments could be made and what kind of risks hospitals would be willing to take under a global payment system.

Ray Campbell

No, I'm saying many of us at this table already have global payment systems, right?

Jody Gittell

Right.

Ray Campbell

So we already have the risk.

Jody Gittell

Right.

Ray Campbell

So because we have the risk, the insurance companies don't. There's reserves that they have that now they theoretically should not need as much of because we're to take that money and put it into a fund, and let hospitals borrow against that fund, make it up on the backside meaningful use, and they can pay it back that way.

Jody Gittell

Right, I'd love commentary on that. Plus, the question of whether that would happen voluntarily or have to be required.

Ray Campbell

Well you know the answer to that one. (laughter)

Jody Gittell

And is it politically feasible? But commentary on -- it's kind of along this theme of either partnering with or somehow working in a different way with the insurers to achieve these outcomes.

Q

I'd like to actually disagree with Ralph's point that upfront infrastructure payments equals paperweights. In my world, upfront infrastructure equals care managers. It allows me to hire the people I need to actually work the patients and to work on care plans, not business plans. What that means is that if I have the money to hire them, I don't have to wait 18 months, which is what it takes to get a reserve and to see the surplus and all the rest of it. So without the opportunity for seed money, for networks like ours that don't have large capital partners behind them, it's really difficult.

Ralph de la Torre

Yes. No, you're missing the point. So what I was talking about is you can have that money day one, right? But there's some hook to providing that borrowed money back unless you deploy it in a meaningful fashion. In other words, you borrow the money. It can be no interest, and then if you meet some meaningful use criteria for deployment, then that money is free. It's forgiven or whatever, but you can't just go to -- and you guys are a different system. I mean, all three of us are up here because we have large systems and infrastructures already, so what we're doing is we're filling in individual IT needs and we have a lot of the system. For a lot of places in the community, they have nothing of what we're talking about, so if you gave them -- here's $20 million, go do it, you know, you're going to get waste. It's better off to say, here's $20 million. Here's what you're going to need to do to have that loan forgiven, and then have them implement it rather than it be a complete gift.

Q

So then we agree that we do need upfront.

Ralph de la Torre

Completely. No, no. I'm just saying there needs to be something other than just, here's the money and walking away. Because if you just throw the money over the fence and walk away, we, the taxpayers, are not going to get what we paid for.

Q

Agreed. We shouldn't underestimate how hard it is to actually make the system work. It requires sort of the day-to-day as Howard was talking about in his comments. This isn't something that you flip a switch and suddenly, everybody knows how to do care management, and everything's wonderful and the IT systems always work. It requires day in and day out.

Jody Gittell

You can have the motivation exactly right and still not know how to do it. It's a big challenge.

Ray Campbell

But you can have hospital networks like we have that actually joined some of our systems. I mean, Cape Cod basically is part of our contracting and infrastructure. They're completely independent from us financially, but they share all of our infrastructure, care management, case management, for all management, and rather than duplicate or try to build it themselves, they just annex and since some of us already have it, that's an opportunity a lot of providers can take.

Jody Gittell

Yeah. I'd like to -- there's still several questions, I think, on this general theme, but like to move into them -- one is, for the three health care systems or provider organizations represented up here, how do you handle behavioral health integration and how do you justify the investments in it?

Q

Hmm, I'll take it at some point. (laughter)

Howard Grant

We don't. I've been here seven months and we've got behavioral health services that are provided and because there's a limited number of resources available, we try to make them available on a priority basis to those patients that we are already providing other types of care for, so that we can take advantage of the integration of the clinic model, but it's very limited in terms of numbers of folks available. We, in my both my experience both at Temple and at Geisinger, in both cases, we, through the support the insurance company, embedded behavioral health specialists into primary care settings.

Jody Gittell

Was that part of the payoff you got from this?

Howard Grant

Well if you're all on the same team, and it's the same bucket of dough that gets split in a variety of directions, and you know that historically somewhere between 20-40% incremental medical and surgical expense occurs for patients with behavioral health disorders that are either not diagnosed or inappropriately treated, it's a prudent business decision to embed behavioral health capability in primary care settings because it's going to come back to you in multiples financially, but more importantly, it's making services available and support available to primary care physicians to be able to have the tools that they need in the face of, in most instances, an inadequate number of either child psychiatrists or psychologists. We have two child psychiatrists for two and a half million people in north central Pennsylvania -- two. My wife was one of them. (laughter)

Jody Gittell

You didn't see her much, did you?

Howard Grant

Well, but the point is, it was -- we were never going to have enough resource to be able to provide the type of care that was necessary, so we embarked something similar that I'm interested in learning more about. We embarked on intensive training for primary care providers in rural settings and embedding in pods of primary care practices, behavioral health specialists, so that they would be a resource available to those folks. But unless you're bearing the full risk in making prudent decisions, then we're left with the way it has historically been in a fee-for-service environment, where behavioral health gets carved out, and we're given full permission to pay no attention to it.

Jody Gittell

Right. Right, so just describe -- and maybe it's really obvious to everybody else, but what are the obstacles to making those product business decisions at Lahey, for example, seeing how you have direct experience of how it pays off?

Howard Grant

Well so Lahey historically, as I understand it, was in the full risk capitation mode years ago and was actually quite successful in providing care in that model because we are a very efficient, low-cost provider by most of the metrics that you look at it right now, and that's part of the benefit of all the doctors being under the same roof and sharing their patients.

Jody Gittell

Right.

Howard Grant

So right now, it's not tended to, but were we to transition to full risk, which I expect we will in not too distant future, I would not want the behavioral health carved out. I want it part of the whole enterprise, and I would like to make prudent decisions to make sure we deliver the best possible care, and we should be the benefactors of that in the full risk environment.

Jody Gittell

Right, get the return on the investment.

Howard Grant

The financial benefits. Absolutely.

Jody Gittell

Doctor de la Torre?

Ralph de la Torre

Yeah, I mean, Howard, I can't agree with you more. I mean, no single service benefits from global payment payment reform more than behavioral health because there is an immediate impact of keeping those patients healthy. You know, when you're talking about long-term outcomes, like you know, dealing with morbid obesity and diabetes, those are things that require years to

play out. Mental health doesn't. That plays out in rather short order, so you know, we have a system and so we do very well at inpatient, and we are struggling to make up the resources on an outpatient basis. So we're the largest provider of inpatient behavioral health services in Massachusetts. We have a very integrated model. All calls, all placement, come through one central location because those patients, you need to find a bed, for the worst thing for one of those patients, to keep them in the emergency room for four days while you try to make a bed available. That's a disaster. So we have centralized service. We have a system Vice President that coordinates psychiatric services, so we have a very integrated model on the inpatient side.

Jody Gittell

Yup.

Ralph de la Torre

We're still struggling to build the infrastructure on the outpatient side that's necessary to really keep those patients

out of the emergency room, but again in a global payment system, you know, as Howard was pointing out, if we don't do it, it's going to cost money. So there's an incentive that's not just -- which doesn't exist in the fee-for-service system unfortunately. In the fee-for-service system, you kind of look the other way and hope they go some place else, and then nobody gets care and it's a disaster. So, you know, I think that from our perspective, we've done a very robust job of trying to integrating the inpatient. We're trying to integrate outpatient. It's going to take more time, but we're committed to it.

Jody Gittell

Yup. Commissioner Leadholm, and then to Doctor Cantor.

Michael Cantor

I'd like to add just one more quickly.

Jody Gittell

Oh yeah.

Michael Cantor

So we actually, as part of our patient center medical home, pilot, have a contract with Tufts Medical Center Department of Psychiatry, so they are available consults and psychiatrists to coach our care managers and to provide -- it's not by accident of course that Tufts contracted with the MCPAP program, so we have the expertise in our tertiary quaternary care center to provide distributed behavioral health benefits. We recognize upfront that just having a nurse -- our teams include a nurse, pharmacist, behavioral health, health coach. So it isn't just an additional nurse who's dropped in. There's a whole team of people that address the different aspects of the care, that complex patients being treated in a primary care setting need. 90% of behavioral health is treated in primary care and there's no capacity in the behavioral health system to take any more of those patients into that system. So unless we figure out how to do the things that we're trying to learn and disseminate as we disseminate our patients in our medical home program, we're

going to be stuck with a lot of very sick people and a lot of really difficult challenges because the comorbidities between behavioral health programs and physical health -- diabetes is a really good example. The depression rates are very high. People don't think that they can take care of themselves and they don't take care of themselves and they get medically ill, and it's one terrible cycle that could be very hard to break. That's the kind of patient that we're focusing on and trying to build services around.

Jody Gittell

And what enables you or encourages you to make those investments in your practices, whereas others don't see the payoff yet in their payment environment?

Michael Cantor

Because we're at risk contracts.

Jody Gittell

OK.

Michael Cantor

And so it's how it's said. It's the same market of money. Here's your opportunity for us. It's better care and it's much more satisfying for providers.

Jody Gittell

Right.

Michael Cantor

Especially a pediatrician struggles so hard with -- because the number of patients they see now for behavioral health, it's almost a third of their practice in some cases, is about managing ADHD and school difficulties and substance abuse, so the world has changed in primary care. Even in pediatrics, I'm

a geriatrician, but my pediatrics colleagues, they're dealing with the same challenges that I am in terms of how to integrate teams of people who usually are treated for very different systems that don't ever talk to each other.

Jody Gittell

Right, right. And one thing I've heard from people who in primary care is, you either do the right thing and take the time with that patient or you just send them on and if you do take the time, there goes your schedule for the whole day, and people are frustrated and everyone's waiting, but to be able to divert and plan, Intermountain Health has an interesting mental health integration model that they've been trying to share with others. Commissioner Leadholm?

Barbara Leadholm

Just a couple comments. In terms of, I think, culturally, the organization has to view, just as been mentioned here, that somehow behavioral health has something to offer and I think there's historically been a lot of either stigma, people are

afraid of behavioral health, or people think, oh it's just those people who want to talk for years. And I think there's now a recognition that the comorbidity is actually quantifiable and you will get better outcomes. I think what I want to kind of acknowledge is, I think we in the behavioral health field, have been part of the problem. We have not been willing to accommodate a primary care or pediatrician's schedule. You know, we'll see it two weeks from now for 15 minutes and you don't make that handoff, so what we're seeing in terms of successful models, are when the clinicians, whether they're psychiatrists or other disciplines, they're actually available to meet the primary care provider, what's their schedule. So am I just on call? Am I ready to just drop in as needed? And then we can triage, or is it more the model like MCPAP, where you're actually consulting, and you're saying, look we'll help you. I can do probably half of this over the phone. I don't need to see the person. But you have to have that triage function. I think the other part for me is that there's some privacy issues that I think historically, the behavioral health community has said, well we can't talk about that. We can't share that with you. So we kind of made that delineation that I think now, people are really much more acknowledging. Yes, there are certain things that need to be protected. There are other things that do not, and usually the primary care folks to support them,

either continuing to work with the client or family, or to just coordinate the care because you actually do a handoff to a behavioral health person. There are really very basic pieces of information that will improve the outcomes and the providers, whatever side they're on, will feel they're part of a team, rather than, you know, there's this kind of line that you cannot cross. I also just want to applaud people understanding -- the business model says it makes sense. I mean this is not just me as an advocate and I think the only thing I would add maybe to hear anybody else who wants to talk about it, it is important for the people who have complex needs, but I would argue even for kind of the more basic, you know, an acute depression, to invest in that early identification and just support the person so that it does not become a complex need. I think at some point, we're going to have to talk about, how do we tier this? How do we really prioritize, and again, I don't know how the organizations are deciding what kind of investments they need to make, but I do think we have to figure out how to take care of the folks that many of which will have a quicker fix, if you will, and then some who will really be long-term, more chronic support, and then I guess I just want to acknowledge the outpatient side of it. I think frequently the problem with the inpatient/outpatient conversation, is it's pretty medically necessarily focused, and I think what we're learning, recovery

really can benefit for a lot of folks with peer support, care management, care coordination. You don't really need a specialist to see you and so we have models that we've not been able to get people interested in that are really less medical. They kind of focus on, well is this medically necessary? And it is a more supportive function, not necessarily a psychiatrist who's going to prescribe medication or a social worker or nurse who's going to have individually oriented therapy or family therapy. It's really much more of a supportive function that a lot of people could provide as long as they were well-trained and really understanding what is the objective criteria by which we would determine, are they adding something that's objective.

Jody Gittell

That's right. And then for those supportive providers to be in communication with each other and with the specialists, in order for them to do what they do effectively. It's really interesting your comment that you may be able to segment over time, people who have these more long-term needs versus the short-term needs and I would just wonder if over time, that long-term portion would go down as we move more into early identification and treatment. You may actually get a change in that proportion.

And we've solved almost everything, but I have two other questions. One is this notion of scalability and the small provider groups because some of these investments are much easier obviously to make their certain economies of scale of a larger group and you addressed that in particular due to the nature of the providers in your network, Doctor Cantor. Just wondering, is that a place where we need to think about public financing of the infrastructure needs of these smaller practices or I guess to be provocative, should we let them or over time be forced to move into larger entities in order to afford those investments, consolidation mainly? I don't know if anyone has thoughts on that.

Michael Cantor

You said that. I didn't say that. Our experience was that the small private practice, when supported appropriately, not only realizes comparable results to those physicians and other providers who are employed in the group, but actually they were more nimble and able to respond more effectively, particularly when provided with the appropriate incentive. So the incentive structure that I'm talking about is actually sharing with the providers, either in the employed group or the private group,

the actual percentage of the savings that are realized by delivering higher quality care, so quality thresholds is a break point, branch point, for deciding whether or not somebody can share, but if they achieve all the quality metrics, then if better results are achieved, lower hospitalization rates, better compliance with pharmaceuticals, et cetera, et cetera, sharing the savings with them and really push them to adopt evidence-based best practices in the delivery of care, but make it a significant financial reward for doing so, and it's irrelevant from whom they get a paycheck in order to get them to adopt that process.

Jody Gittell

So they're giving up some autonomy, but becoming part of a larger entity that enables them to make these investments.

Michael Cantor

Absolutely.

Jody Gittell

Yup. Other thoughts?

Michael Cantor

We've actually seen this in our network over the last couple of years. We're part of the BlueCross BlueShield Alternative Quality Contract.

Jody Gittell

Got it.

Michael Cantor

So we have a complex set of quality measures and Ralph's group is in this too, and we've seen significant improvement across our network, as measured by HEDIS measures that demonstrate better cancer screening for example, better outcomes in processed measures for patients with diabetes and high blood

pressure and heart disease. I think the answers have to be diversity and choice. And so no one should be forced to give up their private independent practice that they've worked 20 years to build. What they should be given is what Howard just talked about, which are the resources to make that just as efficient and as effective as a group, as a physician's practicing in a large building with a lot of other physicians in the same room. In fact, if you look at the data that the Attorney General and the Division put together for these hearings, what you see is that some of the larger, more integrated groups in our state, are actually the higher cost providers in our state and so I think it raises questions about whether -- and there's no correlation between size of group and quality and all the rest of it. We've seen that from the same data.

Jody Gittell

Right.

Michael Cantor

So I think it's really about -- goes back to this issue of infrastructure and how do you know that you're getting really valuable infrastructure. Ralph's point before, not just making massive investments for the sake of saying you have the infrastructure in place.

Jody Gittell

Right, but who will give them the resources in that case, if they're maintaining their autonomies?

Michael Cantor

Well I think is where there has to be the transfer of resources from places like insurance companies...

Jody Gittell

Got it.

Michael Cantor

...where it doesn't belong today, to the physician networks like NEQCA can be the convener, or there may be other structures and other states that have done it very differently. For patients in their medical home, they just have regional teams that work with independent practices. So I think, of course, a network is a fantastic solution, but it's certainly not the only one.

Jody Gittell

Right. Right, so if you transfer some of those payments or share with the insurers, the large groups could do that as well, so you still may have a relative disadvantage to being a small provider group.

Michael Cantor

I think disadvantages as we've heard by now.

Jody Gittell

Yeah, it could be diseconomies of scale, of being too large as well. Yeah, good point. Ralph? Doctor de la Torre?

Ralph de la Torre

Oh no, Ralph's fine. You know, complete autonomy is not conducive to either high quality or low cost health care, period. It's not conducive on the patient level. It's not conducive on the physician level. And you know, I hate to tell Americans this, but the time of rugged individualism is out when it comes to health care reform, and we're going to have to give up some of our complete and total autonomy. You know, when, as a population or as a provider network, we say, you know, I want to be able to go to any doctor at any time and do anything I want and when you have a physician who says, I want to be able to do anything I want, prescribe anything, send anybody anywhere, those two paradigms are just not conducive to our fiscal reality, and so I think that we need to come to grips with that and we need to move on.

Jody Gittell

And may not even be conducive to coordination. It's not clear. Coordination...

Ralph de la Torre

Well quality, let's think about quality, right? So quality, in order to get any kind of -- most of us that have published scientific articles, know that any kind of good number to get any good specificity and sensitivity, you need a large n. You need some large sample, right? If everybody does everything completely differently, you're never going to get a large enough sample to make judgments based on quality. You're not going to get any kind of comparative effectiveness research to guide us as a population. It's just going to be this quiet mar of data that we can't understand. So even at the most fundamental quality level, kind of having a reproducible way that we do things is going to help guide us over time to achieve the highest quality we can.

Jody Gittell

Right, but Doctor Cantor's really speaking up in favor of adopting protocols and standards across even highly independent practitioners.

Ralph de la Torre

Oh, that's exactly what he said. Yeah, yeah. Absolutely. Yup.

Jody Gittell

Final question because this has been very -- I don't know if this is an easy one or a tough one, but this notion I think I also got it from several of the testimonies given today -- so with payment reform, say we move to global bundled payments. How do we do that without replicating the inequities that occur when we just make these payments based on historical budgets and what is the alternative?

Ralph de la Torre

This is one of my pet peeves and I think it's something that the Attorney General's report brought out that hasn't really been discussed, at least that I've seen, at length, which is that there are enormous inequities right now in health care delivery that are socioeconomically based. The poor people tend to get less health care. That's in our system now. Now, that is actually made even worse when you realize the way that insurance products are priced. I mean, everybody pays the same premium for the same program, but yet, one subpopulation, especially if it's a capitated product, where they have budgets behind the scene that people don't realize are there, you know, one subpopulation actually has a lower budget than the higher population and the population that has a lower budget tends to be the poorer, so you have this reverse robin hood phenomena that's occurred, where you're actually subsidizing the care of the rich from the poor, which makes no sense because of these budgets that are built in behind the scenes. It's a tough question though because in order to get physicians, providers, and everybody to really take the first big step, which is payment reform, you can't do it purely based on demographics. There has to be some historical component to it.

Jody Gittell

Otherwise, it's too much of a shock. People can't adjust.

Ralph de la Torre

Exactly. So I think that what we need is a way to begin, based on historical performance, and move to some kind of a weighted demographically based payment modality so that everybody gets treated more fairly in the system.

Jody Gittell

Right, some way of transitioning that.

Ralph de la Torre

Yeah.

Jody Gittell

I'd like a comment from anyone who wants to speak on this issue, and then we do have to stop. We're at the end of our time.

A

Transparency of pricing.

Jody Gittell

Elaborate just a touch.

A

Make them public. Why is it a secret? I don't understand how a market can function when you don't know what people are getting paid.

A1

It's not pricing though. But see, therein lies a problem that it's not pricing because in a large, you know, HMO that has these capitated rates built in, different people are assigned different budgets behind the scenes based on the historical performance, so you have the pricing of the hospital, but it's how the individual practitioner conceives health care that drives the budget of their patient. So if what you're saying is, transparency i.e. you have to tell patients if you take this product, you will have a budget of X, but can you imagine what that would do? You say to a patient, well you know, you're paying the HMO Blue rate, whatever that is, make up a number, a million dollars. So it's not relevant. And if you go to this doctor, you know, your budget's going to be 1.2 million, and if you go to this doctor, your budget's going to be 800,000. Well who the hell is going to go to the lower one?

Jody Gittell

Yeah. Other thoughts?

A2

I think that the reality is, and we've seen it from data from last year's report and this year's too, is the significant difference in price unit costs between provider networks in hospitals in this state. We know that that's the truth. If you don't remedy that disparity, we've already created a haves and a have nots world. Being in the lower level, lower cost, or higher quality lower cost, which is a really good thing, the problem is it's harder for me to build the infrastructure that I need when I don't have that margin to take from to hire the people and to compete with the other people who do to be able to attract the best talents, to be able to get the best analysts, and be able to get the best nurses and doctors that I need to provide care for our patients. So I think that unless, if we just say we're going to take whatever it is in 2011 and keep that price structure in place, we're going to continue to disadvantage groups like ours unfairly, not based on quality, but based on historical realities and negotiating power at the bargaining table. That's not the way to decide how to allocate health care resources. They should be allocated based on need and complexity and the opportunity to make a difference in peoples' lives, and that's what has to be addressed. It really makes me angry that in one particular plan, the quality

incentives are based on total medical expense. So because I have a lower budget to begin with, my opportunity for the same level of quality to get the incentive payments that you were talking about before, is less because of that historical accident of which network, which group I decided to belong to ten years ago.

Jody Gittell

Right. Right, so using this historical rates actually reinforced this inability to invest to get out of that lower rate position. Interesting. Final commitment? Actually, we'd like to hear from Commissioner Leadholm as well.

A3

I think the market is beginning to figure it out. Certainly employers are figuring it out. My concern is that given the financial constraints that most states in the federal government have today, that if left to the market only, it won't get there quick enough, and will be relegated to some type of solution in the form of price controls or some other fixed regulatory

environment, which will discourage innovation and the type of creativity that you've heard about from people on the panel today.

Jody Gittell

Right, so you're advocating a public sector solution of some kind to rectify the inequities.

A3

To accelerate it.

Jody Gittell

To accelerate what will happen anyway, but not fast enough.

A3

Absolutely.

Jody Gittell

OK. Interesting. Commissioner Leadholm?

Barbara Leadholm

Unfortunately, my perspective's mostly on Medicaid and more people who are getting the subsidized, and I just think it's a whole different conversation, so I'm not sure I can contribute a lot to this, other than to say that the models have to really look at not only historical utilization, but then put in some other kinds of indicators and it's not just acuity because frankly, I would say that for some of the more complex folks who are not necessarily using either their Mass Health or if they're in a regular insurance plan, they're just more expensive possibly because they're not using care period. And so, you know, I think we really have to put our heads together and say, how would you really look at utilization, put in the analytics, and then decide what kind of model really fairly thinks about where you want to be in the future rather than just where we were historically.

Jody Gittell

Right. Right, and that's a very data-intensive process. OK, so I thank you all so much, and I hope we've together provided some useful input to the commission. Thank you. (clapping)

Q

Thank you panelists for your time, and thank you Jody for moderating the panel. So I heard two quick themes before we break for lunch. The first being that conversations or arrangements to be decided between payers and providers are needed for appropriate investments and infrastructure, but there should be also a recognition of community utilities, wish to be funded with public and private funds. And the second being that we need better integration in behavioral health with other parts of the delivery system and that's most effectively encouraged and developed through risk contracts. So we're naturally now going to break for about a half-hour lunch. I know lunch started a little late, so the second session will probably pick up around 1:20 or so. Doctor Paul Ginsburg then will be

providing his expert testimony on the role of government and market.

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